

Practice Management

Recent Developments in Evaluation and Management Services

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Evaluation and management services are important aspects of interventional pain management; however, significant confusion continues as to proper coding and documentation in this field. In addition, recent developments in the area of evaluation and management services over the last few months are of significance to interventional pain physicians.

Two major developments in the year 2000 include a warning from the Health Care Financing Administration (HCFA) with regards to misused codes, and issue of new draft evaluation and management guidelines to improve physician acceptance by simplification.

The HCFA has sent letters to all physicians in the United States on June 1, 2000, with information that it will be focusing this year on two current procedural terminology (CPT) codes used to report evaluation and management services – 99214 and 99233. The HCFA contends that these

codes accounted for a significant portion of coding errors in the last two audits and that documentation for many of these services was found to be sufficient only to support services more appropriately described by CPT codes 99212 and 99231 resulting in downcoding by two levels by HCFA and implying that physicians are upcoding by two levels.

The second issue relates to the release of yet another version of the new draft evaluation and management guidelines by HCFA in June 2000. These were preceded by an article by the administrator of HCFA, Nancy-Ann Min DeParle, which was published in *JAMA*. The new guidelines are purported to eliminate “bullets” and “shading”; reduce the need for counting the “elements”; introduce the first specialty-specific vignettes; and include a nationwide study of the new proposed guidelines.

Keywords: Evaluation and management services, new framework, CPT codes, interventional pain management.

“It is as important to know the person who has the disease as to know the disease the person has.”

Sir William Osler

“A doctor who cannot take a good history, and a patient who cannot give one are in danger of giving and receiving bad treatment.”

Anonymous

“More mistakes are made from want of proper examination than for any other reason.”

Russell Howard

Evaluation and management services continue to be important aspects of interventional pain management. Even though there has been significant confusion over the proper coding and documentation for evaluation and management services in general and for services in interventional pain management in particular over the last few years, there have been significant developments in this arena over the last few months, i.e., from May 2000. Pain physicians know, as well as other physicians, if not better, the value and importance of evaluation and management services.

The importance of evaluation and management services in interventional pain practices has been well described (1-4). Recent developments in evaluation and management services once again underscore the importance of understanding evaluation and management services and their appropriate documentation. Two major developments in recent months include the Health Care Financing Administration’s (HCFA’s) warning to physicians about misused codes and refinement or issue of new draft evaluation and management guidelines to improve physician acceptance by simplification.

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MISUSED CODES

Nancy-Ann Min DeParle, administrator of HCFA, in a letter to physicians dated June 1, 2000, warned that Medicare auditors will closely monitor two current procedural terminology (CPT) codes used to report evaluation and management services: established patient-visit CPT 99214, and subsequent hospital-care CPT 99233. The essentials of the letter were as follows:

We have all been working hard to protect the Medicare program, and we have had good success. Four years ago, we took our first measurement of payment errors and found 14 percent of Medicare dollars were incorrectly paid. Last year, we saw that rate fall to less than 8 percent and we sustained that improvement this year – proving that we have made real progress, but also demonstrating that we still have to go further to meet our goals.

Today I want to emphasize the importance of close attention to billing requirements, especially for documenting services delivered and the reason for care, as a way to ensure you receive and Medicare makes proper payments. Many of you have invested in compliance programs and other approaches to ensure proper billing, and we commend you for your diligence. We want to as-

sure you that we want to make it easier for you to comply with our rules, and to distinguish between different kinds of errors.

For physicians, we will be focusing this year on two CPT codes used to report evaluation and management services – 99214 and 99233. These codes accounted for a significant portion of the coding errors in the last two audits. In fact, documentation for many of these services was only found to be sufficient to support services more appropriately described by CPT codes 99212 and 99231. Please make sure when you bill for an office or other outpatient visit using CPT code 99214 that you are documenting at least two of the following three key components: a detailed history, and/or a detailed examination, and/or medical decision making of moderate complexity. Using CPT code 99233 for subsequent hospital care requires documentation of at least two of these three components: a detailed interval history, and/or a detailed examination, and/or medical decision making of high complexity.

One final note: The Health and Human Services Inspector General has begun the Fiscal Year 2000 error rate study and

Table 1. *Various types of CPT codes utilized for evaluation and management services relevant to pain management*

New Patient Office Visit(s)	Established Outpatient(s)	Office Consult(s) New or Established Patient(s)	Initial Inpatient New or Established Patient(s)	Subsequent Hospital Care	Initial Inpatient Consult(s)	Follow-up Inpatient Consult(s)
99201	99211	99241	99221	99231	99251	99261
99202	99212	99242	99222	99232	99252	99262
99203	99213	99243	99223	99233	99253	99263
99204	99214	99244			99254	
99205	99215	99245			99255	

is reviewing a sample of Medicare claims from around the country. If any of your claims are randomly selected as part of this review, we urge you to provide the appropriate documentation as quickly as possible. This will help demonstrate that the payments that you received were proper.

Following this letter, various local Medicare carriers have issued notices that the reviews will be focused on CPT codes 99214, and 99233. The CPT code 99214 is the second highest level of evaluation and management service for an established patient in the office or other outpatient setting. Similarly, CPT code 99233 is the highest level of evaluation and management service for subsequent hospital care, per day (5). Table 1 shows various types of CPT codes utilized for evaluation and management services relevant to pain management. The description of the two codes being focused on are:

- ◆ **99214 Office or other outpatient visit** for the evaluation and management of an established patient, which requires at least two of these three key components:
 - **A detailed history;**
 - **A detailed examination;**
 - **Medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs (6).

Usually, the presenting problem(s) are of moderate-to-high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

- ◆ **99233 Subsequent hospital care**, per day, for the evaluation and management of the patient, which requires at least two of these key components:
 - **A detailed interval history;**
 - **A detailed examination;**
 - **Medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs (6). Usually, the patient is unstable or has developed a significant complication or a significant new problem.

As shown in Table 2, CPT code 99214 was used 21% of the time by all specialists, whereas it was used 19% of the time by anesthesiologists, 25% of the time by physiatrists and 39% of the time by neurologists. As shown in Fig. 1, if one believes that following a bell-shaped curve is safe, only neurologists have significantly exceeded the average.

Table 2. Utilization for year 1998 for all established patients and speciality practices of anesthesiology, physiatry, and neurology

CPT Evaluation Code	Total Visits by Category for All Specialties		Visits for Anesthesiology		Visits for Physiatry		Visits for Neurology	
	No. of visits	Percent	No. of visits	Percent	Visits	Percent	Visits	Percent
99211	8,609,050	5%	35,478	6%	27,319	4%	35,698	1%
99212	29,884,479	18%	166,124	29%	121,944	19%	217,643	8%
99213	86,124,315	52%	243,592	42%	306,568	47%	1,073,467	42%
99214	34,128,560	21%	107,740	19%	159,242	25%	990,981	39%
99215	6,263,370	4%	22,952	4%	31,595	5%	249,526	10%
Total	165,009,774	100%	575,886	100%	646,668	100%	2,567,315	100%

Source: HCFA Utilization Statistics 1998

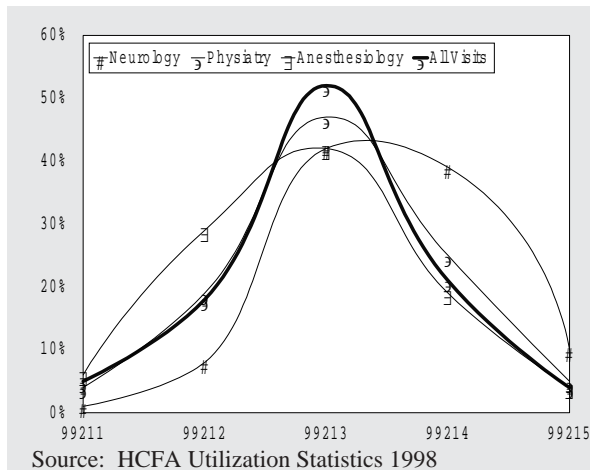


Fig 1. Comparison of 1998 E/M utilization data - established patient office visits

However, the letter from the administrator of HCFA stated that CPT 99214 accounted for a significant portion of the coding errors in the last two audits; and, in fact, as for HCFA, documentation for many of these services was found to be sufficient only to support services more appropriately described by CPT 99212, and indicating upcoding by two levels. Obviously, this does not support the traditional wisdom of following the bell-shaped curve.

CPT 99214

History

History requires a detailed interval history that includes:

- ◆ *Chief complaint;*
- ◆ *History of present illness* – extended, including at least four elements or status of three chronic or inactive conditions;
- ◆ *Review of systems* – extended, which includes positive and pertinent negatives, two to nine systems);
- ◆ *Past, family, and/or social history* – pertinent – which includes history pertinent to problems identified in the history of present illness.

However, a review of systems and/or past family and social history obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many

physicians use a common record. The review and update may be documented by:

- ◆ Describing any new review of systems and/or past family and social history information by noting there has been no change in the information and/or
- ◆ Noting the date and location of the earlier review of systems and/or past family and social history.

Physical Examination

Physical examination for this level of evaluation and management services includes a detailed or an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system (s).

In general, a multisystem examination includes examination of at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet are expected. Ordinarily, a detailed examination may include performance and documentation of at least 12 elements identified by a bullet in two or more organ systems or body areas.

In a single-organ-system examination, a detailed examination includes examination of symptomatic and related-systems, with documentation of at least 12 elements identified by a bullet.

Decision Making

Type of decision making should be of moderate complexity, which involves:

- ◆ Number of diagnosis or management options, multiple;
- ◆ Amount and/or complexity of data to be reviewed, moderate; and
- ◆ Risk of complications and/or morbidity mortality, moderate.

Time is used only as a guidance. If either counseling and/or coordination of care dominates the physician/patient and/or family encounter (face-to-face time in the office exceeding 50% of the time), time is considered the key or controlling factor to qualify for a particular level of evaluation and management service. If the physician elects to report the level of service based on counseling and coor-

Table 3. Utilization of initial inpatient and subsequent hospital care visits for 1998, for all specialties; and specialty practices of anesthesiology, physiatry, and neurology

CPT Evaluation Code	Total Visits by Category for All Specialties		Visits for Anesthesiology		Visits for Physiatry		Visits for Neurology	
	No. of visits	Percent	No. of visits	Percent	No. of visits	Percent	No. of visits	Percent
99221 Initial	601,318	1%	3,492	2%	23,885	1%	9,011	1%
99222 Initial	3,063,172	4%	3,999	2%	87,865	2%	34,672	1%
99223 Initial	4,506,558	6%	3,305	2%	114,661	3%	67,879	3%
99231 Subsequent	23,359,861	30%	98,555	52%	2,108,548	58%	985,160	39%
99232 Subsequent	34,269,766	43%	51,154	27%	1,050,522	30%	1,064,203	42%
99233 Subsequent	12,312,919	16%	27,668	15%	228,667	6%	357,958	14%
Total	78,113,594	100%	188,173	100%	3,614,148	100%	2,518,883	100%

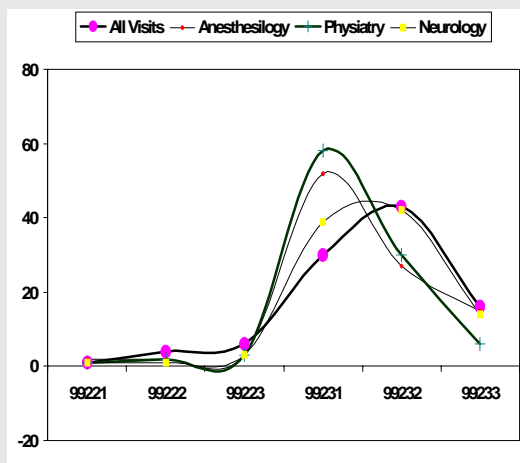
Source: HCFA Utilization Statistics 1998

dination of care, the total length of time of the encounter (face-to-face) should be documented and the record should describe the counseling and/or coordination activities.

CPT 99233

As shown in Table 3, 99233 was utilized by all specialists

on 16% of the claims, whereas anesthesiologists utilized it on 15% of the claims, followed by neurologists in 14% of the claims, and 6% of the time by physiatrists. Thus, as shown in Fig. 2, if a bell-shaped curve is utilized, all interventional pain specialists, including anesthesiologists, physiatrists and neurologists, fall below the average utili-



Source: HCFA Utilization Statistics 1998

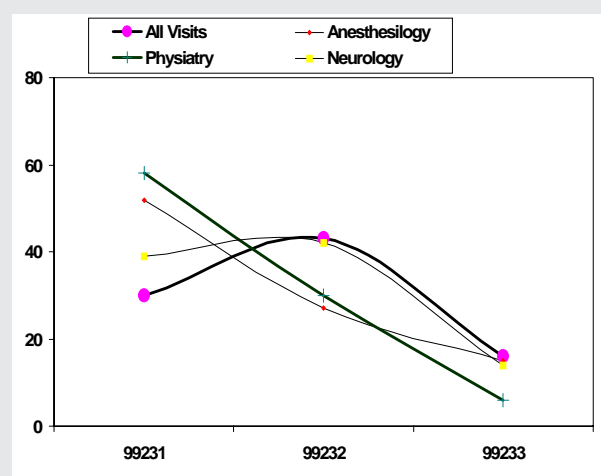


Fig 2. National Average for Utilization of E/M Coding - New patients

zation of the code. However, once again, the theory of staying within the bell-shaped curve is only of superficial value. The administrator of HCFA in her letter stated that code 99233 accounted for a significant portion of the coding errors in the last two audits; and, in fact, documentation for many of these services was found to be sufficient only to support services more appropriately described by 99231, ie, thus again indicating upcoding by two levels.

As per the evaluation and management guidelines, CPT 99233, subsequent hospital care requires the following:

History

History requires a detailed interval history, which includes:

- ◆ *Chief complaint;*
- ◆ *History of present illness* - with at least four elements or status of three chronic or inactive conditions;
- ◆ *Review of systems* – extended positive and pertinent negatives;
- ◆ *Past family and/or social history* - pertinent to problems identified in the history of present illness.

However, a review of systems and/or past family and social history obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:

- ◆ Describing any new review of systems and/or past family and social history information by noting there has been no change in the information and/or
- ◆ Noting the date and location of the earlier review of systems and/or past family and social history.

Physical Examination

This level of evaluation and management services includes a detailed examination.

A general multisystem examination should include at least six organ systems or body areas. For each system/area elected, performance and documentation of at least two elements identifying a bullet is expected. Ordinarily, a detailed examination may include performance and docu-

mentation of at least 12 elements identified by a bullet in two or more organ systems or body areas.

In a single-system examination, at least 12 elements identified by a bullet should be documented.

Decision Making

This should be of high complexity involving the following:

- ◆ Number of diagnoses or management options – extensive;
- ◆ Amount and/or complexity of data to be reviewed – extensive; and
- ◆ Risk of complications and/or morbidity or mortality – high.

Time required for this evaluation and management code is 35 minutes at the bedside and on the patient's hospital floor or unit. However, time is only important if either counseling and/or coordination of care dominates the physician/patient and/or family encounter, with face-to-face time, exceeding 50% of the time, which in fact becomes a controlling key or controlling factor to qualify for a particular level of evaluation and management service. If the physician elects to report the level of service based on counseling and coordination of care, the total length of time of the encounter, face-to-face or flow time, should be documented and the record should describe the counseling and/or activities.

Analysis of HCFA specialty utilization for 1998, total evaluation and management services visits showed that they were 322,494,736, with 99214 constituting 34,128,560 visits or 11%, and 99233 constituting 12,312,919 visits or 4%. In addition, as a percentage of Medicare part B claims, which were 696 million, these visits constituted 5% for CPT code 99214 and 2% for CPT code 99233.

NEW GUIDELINES

In the evolution of numerous regulations by HCFA regarding the practice of medicine, implementation of evaluation and management guidelines started in the 1990s. The latest guidelines utilized at the present time were implemented in 1997. Since then, new guidelines were released in 1998 followed by a review draft. Due to a multitude of complaints and differences in opinion between HCFA and the American Medical Association (AMA) and various

specialty medical societies and the inability of HCFA to pilot-test these guidelines, HCFA unveiled new, draft documentation guidelines for evaluation and management services in June 2000, which was preceded by an article by the administrator of HCFA in *JAMA* (6, 7).

The “new framework” evaluation and management documentation guidelines were released in June 1998. It was stated that these guidelines, in some form, would eventually replace the 1995 and 1997 guidelines. However, when the newest version of evaluation and management services guidelines was released on June 22, 2000, it did not resemble the so-called “new framework” (8). Even though 1998 guidelines were reported as a significant improvement over 1995 and 1997 guidelines, in the 2 years since the release of the 1998 guidelines many flaws were recognized:

- ◆ The 1998 proposed guidelines were not work equal and across the various specialties for a given level of service. The current law does not allow for differentials among various specialties, making this a great stumbling block in the implementation of the 1998 proposed guidelines (8). Similar to 1997 guidelines, proposed guidelines for 1999 deviated significantly from the qualitative definitions for examinations and medical decision making (8). It was noted that it was possible under the 1999 draft guidelines to satisfy the numerous requirements for a physical examination while not meeting the qualitative requirements of the CPT definition to examine affected organ systems or body areas. According to HCFA, breaking down the physical examination into a list of elements and then requiring documentation of a subset of those elements to achieve a level of service creates an incentive to perform unnecessary examinations and to record clinically irrelevant information.
- ◆ Medical decision making tables for the 1997 and 1999 guidelines deviated from the CPT definition of medical decision making. The factors that comprise medical decision making, such as patient risk, and amount of data to be reviewed, are significantly rearranged or altered (8). The list of examples for each factor is confusing and often will be clinically irrelevant to the physician and biller attempting to assign a level of service (8). Finally, the assigned level of decision mak-

ing was determined by only a single factor in the decision-making process (8).

- ◆ These are wide discrepancies in the assessment of various codes under 1995, 1996, 1997 and 1999 guidelines by a nonphysician reviewer (registered record analyst, and physician reviewer), and carrier medical director under all three sets of guidelines.

ADVANTAGES OF THE NEW GUIDELINES

To remedy all of the above issues, HCFA released the new 2000 guidelines. The HCFA plans to examine the differences in the visit leveling between physician and nonphysician reviewers under the new 2000 guidelines. The HCFA stated that, in the new guidelines:

- ◆ Physical examination has been simplified to three levels based on the number of organ systems examined. For example, a detailed examination includes findings from three to eight organ systems, rather than the total number of items examined (6).
- ◆ The requirements for review of systems are also based on organ systems.
- ◆ Counting of elements in an examination is virtually eliminated, as are incentives to perform unnecessary examinations
- ◆ Medical decision making has been simplified to three levels, with clear requirements that will be cross-referenced to specialty-specific vignettes to aid reviewers in making accurate determinations. The vignettes will capture the nuances of each medical specialty and prevent arbitrary application of and dependence upon generative, flexible, and often meaningless lists of elements.
- ◆ The HCFA believes that new, simpler guidelines will provide clear and unambiguous guidance and streamline the documentation required for clinically appropriate record keeping and verification that services were medically necessary and rendered as billed.
- ◆ However, HCFA wants to make sure that these guidelines will work in the real world of clinical practice. Hence, vigorous testing of the simplified guidelines is planned. The testing is planned at three levels:

- Pilot testing focusing on the basic region of the original 1995 guidelines that is designed to minimize counting of elements and the uses of a series of physical examination and medical decision-making scenarios to help physicians and reviewers assign a level of service;
- A second version that focuses more on how physicians make medical decisions and less on history and physical examination, involving little or no counting and including medical decision-making scenarios; and
- Testing of training mechanisms.

The HCFA hopes to begin pilot testing in year 2000, with results available as early as summer 2001, and new guidelines in place in 2002 (6). The HCFA also concedes that,

Table 4. *Evaluation and management guidelines advantages of “New Framework” 2000*

- Elimination of “bullets” and “shading”
- Reduction in the need for counting the “elements”
- The first specialty-specific vignettes
- A nationwide study of new guidelines

if test results demonstrate that further work is needed, it will make additional adjustments. However, HCFA must know before proceeding whether it has indeed found a simpler, clinically meaningful, and nonintrusive approach to documentation that all can live with (6). Several purported advantages of new draft evaluation and management guidelines are listed in Table 4.

DRAFT EVALUATION AND MANAGEMENT GUIDELINES

The latest framework of guidelines was released in June 2000 (6, 7). Following is the entire draft of the most recent new framework of guidelines, reproduced from HCFA’s publication (7). These guidelines are not final. They are awaiting pilot testing. It is quite possible that these guidelines may undergo extensive revisions prior to implementation. In addition, HCFA’s draft also mentions appendices A and B, to consist of vignettes which have not been completed yet by HCFA.

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient’s immediate treatment, and to monitor his/her health care over time;
- communication and continuity of care among physicians and other health care professionals involved in the patient’s care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the “hassles” associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E and M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
 - the chief complaint and/or reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
 - assessment, clinical impression or diagnosis;
 - plan for care; and
 - date and a verifiable legible identity of the health care professional who provided the service.
3. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
4. To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
8. An addendum to a medical record should be dated the day the information is added to the medical record and not dated for the date the service was provided.
9. Timeliness: A service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.
10. The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

III. DOCUMENTATION OF E AND M SERVICES

This publication provides definitions and documentation guidelines for the three **key** components of E and M services and for visits which consist predominately of counseling or coordination of care. The three key components—history, examination and medical decision making—appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of

the text of the coding reference, Current Procedural Terminology (CPT) has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E and M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol DG.**

The descriptors for the levels of E and M services recognize seven components that are used in defining the levels of E and M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the **key** components in selecting the level of E and M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E and M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) details of the mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E and M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive.) Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

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

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief (1-3)	N/A	N/A	<i>Problem Focused</i>
Brief (1-3)	Brief (1-2)	Pertinent (1 of 3)	<i>Expanded Problem Focused</i>
Extended (4+)	Extended (3-8)	Complete (2 of 3 or 3 of 3)	<i>Detailed</i>
Extended (4+)	Complete (9+)	Complete (2 of 3 or 3 of 3)	<i>Comprehensive</i>

- *DG: The CC, ROS, and RFSH may be listed as separate elements of history, or they may be included in the description of the history of present illness.*
- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or is in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*
 - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and,*
 - *noting the date and location of the earlier ROS and/or PFSH.*
- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*
- *DG: The physician should document efforts made to obtain a history from the patient, accompanying family members, friends or attendants or emergency personnel (e.g., paramedics) or available medical records (e.g., previous hospital records, nursing facility records, ambulance records). It is rare that no history will be available. Any history obtained will be evaluated according to the guidelines.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

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.

- *DG: The medical record should clearly reflect the chief complaint.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It should provide pertinent details about the reason for the encounter. Types of details include:

- For symptoms: location, quality, severity, duration, timing, context, modifying factors including medications, associated signs and symptoms etc.

- For follow up of a previously diagnosed problem: changes in condition since the last visit, compliance with the treatment plan etc.
- For patients on multiple medications or whose primary reason for the visit is for medication management: review of compliance, effectiveness of medications, side-effects and complications from medications, verification of medication name, dosage and frequency.

Brief and **extended** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

- *DG: A **brief** HPI consists of: documentation of the chief complaint(s) or reason(s) for the encounter as well as 1 – 3 pertinent details about at least one presenting problem.*
- *DG An **extended** HPI documents the chief complaint(s) or reason(s) for the encounter as well as 4 or more details about at least one presenting problem.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following are recognized:

- **CONSTITUTIONAL SYMPTOMS** (e.g., fever, weight loss)
- **ORGAN SYSTEMS**
 - Ophthalmologic
 - Otolaryngologic
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Integumentary (skin and/or breast)
 - Neurological
 - Psychiatric
 - Endocrine
 - Hematologic/Lymphatic
 - Allergic/Immunologic
- *DG: A **brief** ROS inquires about the system(s) directly related to the presenting problem(s)/complaint(s). For example: (I) GI systems for chief complaint of diarrhea; (ii) Pulmonary and Cardiac systems for chief complaint of chest pain. This overlaps with HPI. Generally a brief ROS consists of 1 or 2 organ systems.*
- *DG: An **extended** ROS includes a brief ROS as well as a review of additional organ system(s); generally an extended ROS consists of 3-8 organ systems including the system directly related to the presenting problem(s)/complaint(s).*
- *DG: A **complete** ROS includes a review of 9 or more organ systems including the system directly related to the presenting problem(s)/complaint(s).*

Documenting positive and negative findings: All positive findings must be described; negative findings do not need to be individually documented except as appropriate for patient care: a notation indicating a system was negative is sufficient; the name of each system reviewed must be documented. For example:

(i) the following notations are acceptable:

- “Pulmonary: cough x 4 weeks, otherwise negative”
- “Cardiac: negative”
- “ROS: cardiac, pulmonary, GI, GU, endocrine all negative”

(ii) the following notations are unacceptable:

- “ROS: negative”
- “Pulmonary: positive”
- “All systems negative”

PAST, FAMILY AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (e. g. the patient’s past experiences with illnesses, operations, injuries, medications, compliance, and treatments);
- family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an “interval” history. It is not necessary to record information about the PFSH.

A **pertinent** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- *DG: At least one specific item from any of the three history areas must be documented for a persistent PFSH.*

A **complete** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E and M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment of reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- *DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E and M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*
- *DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E and M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.*

B. DOCUMENTATION OF EXAMINATION

The levels of CPT E and M services are based on four types of examination that are defined as follows:

- **Problem Focused**—a limited examination of the affected body area or organ system.
- **Expanded Problem Focused**—a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- **Detailed**—an extended examination of the affected body area(s) and other symptomatic or related

- organ system(s).
- **Comprehensive**—a general multi-system examination or complete examination of a single organ system.
- *DG: For documentation purposes, problem focused and expanded problem focused examinations are similar and are designated as a “brief examination.”*

For purposes of examination, the following are recognized:

A. BODY AREA

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

B. ORGAN SYSTEMS

- Ophthalmologic
- Otolaryngologic
- Cardiovascular
- Respiratory
- Endocrine
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurologic
- Psychiatric
- Hematologic/Lymphatic
- Allergic/Immunologic

C. CONSTITUTIONAL

(e.g., vital signs, general appearance) A description of a minimum of 3 findings is comparable to one body area or organ system.

- *DG: The medical record for multi system examinations should be documented as follows: (1) a brief examination should include findings from 1 or 2 body areas or organ systems, (2) a detailed examination should include findings from 3 to 8 body areas or organ systems, and (3) a comprehensive multi-system examination should include findings from 9 or more of the 7 body areas or 13 organ systems, or at least 3 constitutional findings that are comparable to 1 body area or organ system.*
- *DG: For brief, detailed, and comprehensive single system examinations refer to the specialty specific single system vignettes in appendix A for appropriate documentation.*

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- *DG: Specific abnormal and relevant negative findings of the examination of the affected or symp-*

tomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.

- *DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- *DG: 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).*

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

In order to determine the level of decision making for an encounter, the medical record should include documentation of an assessment and plan for each problem evaluated during the encounter. The assessment and plan for each problem should include documentation of (1) the status/severity/urgency of the problem(s) and the risk of complications and deterioration, (2) the amount and complexity of data reviewed and differential diagnosis(es), (3) the diagnostic and therapeutic tests, procedures and interventions ordered and the treatment plan.

A. Low complexity Medical Decision Making

Typically, the problem(s) addressed will (1) be of low severity, low urgency and low risk of clinical deterioration and complications, (2) have a limited differential diagnosis and limited review of additional data, (3) have straightforward diagnostic and/or therapeutic interventions, and a straightforward treatment plan. For the purpose of documentation two of these three elements must either meet or exceed the requirement for low complexity.

B. Moderate Complexity Medical Decision Making

Typically, the problem(s) addressed will (1) be of moderate severity with a low to moderate risk of clinical deterioration, (2) require review of a detailed amount of additional information with an extended differential diagnosis, (3) require complicated diagnostic and/or therapeutic intervention, with a complicated treatment plan. For the purpose of documentation two of these three elements must either meet or exceed the requirement for moderate complexity.

C. Highly Complex Medical Decision Making

Typically, the problem(s) addressed will (1) be of high severity with a high risk of complications and clinical deterioration, (2) require review of an extensive amount of additional information with an extensive differential diagnosis, (3) require highly complex multiple diagnostic and/or therapeutic interventions, with a highly complex treatment plan. For the purpose of documentation two of these three elements must either meet or exceed the requirement for highly complex medical decision making.

The following is a more detailed discussion of several of the elements of medical decision making:

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Each of the elements of medical decision making is described below.

NUMBER OF DIAGNOSES OR 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.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- *DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*
- *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*
- *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as “possible”, “probable”, or “rule out” (R/O) diagnoses.*
- *DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications. This is particularly important for patients on multiple medications or whose primary reason for the visit is for medication management.*
- *DG: When consultations are requested or advice sought, the record should indicate to whom or where the consultation is made or from whom the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- *DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E and M encounter, the type of service, e.g., lab or x-ray, should be documented.*
- *DG: The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a 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.*
- *DG: A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*
- *DG: Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of “Old records re-*

- viewed” or “additional history obtained from family” without elaboration is insufficient.
- DG: The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.
- DG: The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- DG: Comorbidities/underlying diseases or other factors (e.g. the number and type of medications) that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
- DG: If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E and M encounter, the type of procedure, e.g., laparoscopy, should be documented.
- DG: If a surgical or invasive diagnostic procedure is performed at the time of the E and M encounter, the specific procedure should be documented.
- DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

The table below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must either meet or exceed the requirements for that type of decision making.**

Severity/Urgency of the problem(s) and Risk of Complications and Deterioration	Differential Diagnoses and Amount/Complexity of Data Reviewed	Treatment Plan including diagnostic and therapeutic tests, procedures and interventions	Type of Decision Making
Low	Limited	Straightforward	Low
Moderate	Detailed	Complicated	Moderate
High	Extensive	Highly Complex	High

Please refer to the specialty specific medical decision making vignettes in appendix B for guidance in using this table.

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E and M services.

- DG: The total length of time of the encounter (face-to-face or floor time, as appropriate) and a full description/explanation of the counseling and/or activities coordinating care must be documented in the medical record.
- DG: Performance of a history and physical examination, although not required at each instance of counseling/coordination of care, should be referred to when appropriate.

- *DG*: Medical decision making associated with this service must be documented as part of the counseling and/coordination of care.

PHYSICIAN REACTIONS

Physicians and their associations reacted cautiously to the release of the new guidelines, with many saying they needed further analysis of the proposal (9). The American College of Physicians – American Society of Internal Medicine commented that, generally, the guidelines have been simplified; and that this certainly was a step in the right direction (9). For some physicians, the unveiling seemed familiar. Trippett, a member of AMA's ad hoc task force on the evaluation and management documentation system, stated, "I feel like a dog chasing his tail today. It seems like we have made a full circle back to where we started" (9). Rudolph, a senior technical advisor for HCFA's Center for Health Plans and Providers, believes that the new focus of 2000 guidelines vignettes is aimed at helping physicians document properly (9). He believes that it is critical for HCFA to eliminate confusion as to how to differentiate between levels of service, and to avoid counting. There has been major criticism from specialists in the past for failing to clarify the requirements for single-organ-system examinations, which can make it hard for specialists to meet the documentation requirements for the

higher levels in evaluation and management services. By creating vignettes, HCFA is trying to resolve this problem. Essentially, as per HCFA, the vignettes will paint the picture – rather than using numbers or a series of words – that physicians can extrapolate from when documenting their work.

Physicians are also concerned that reduction in the number of levels of evaluation and management coding would, in fact, result in cuts in payments to physicians. It is quite justified, as evaluation and management services represent about \$18 billion in Medicare spending and account for about 40% of the program spending on physician services. However, HCFA reiterated that no decisions had been made yet on whether there should be fewer levels of services; but HCFA reinforces that precedent exists for maintaining budget neutrality in such circumstances, meaning that overall physician payment would not be reduced.

COMPARISON OF GUIDELINES

The HCFA has released several sets of evaluation and management guidelines in the past. However, the 1995 and

Table 5. *Comparison and identification of major differences between current (1997) and proposed guidelines (2000)*

Service Component	1997 Requirements	Draft 2000 Guidelines
History		
History of Present Illness	•Specific requirements	•Clearer requirements •Explicit recognition of medication monitoring
Review of Systems	•Specific body area or organ system requirements	•Less required -Clearer •Examples are provided
Past, Family, Social History	•Brief information required	•Extended requirements
Physical Examination	•General multisystem examination and 10 single-system examinations •Four levels •Very prescriptive •Confusing shading and bullets •Requirements often irrelevant	•Physician tailors documentation to examination •Only three levels •Vignette examples •No bullets •No shading •Minimal counting •Only relevant facts to be recorded
Medical Decision Making	•Four levels •Long list of examples •Examples irrelevant to clinical situations	•Only three levels •Physician tailors documentation to assessment and plan of treatment •Vignette examples

1997 guidelines are being used at the present time. Guidelines released in 1998 seem to be ineffective at the present time. Apparently, the new framework of revised guidelines was developed from 1995 guidelines. In addition, HCFA also announced plans to explore changing the five levels of evaluation and management services, possibly reducing them into three. However, changing the levels of evaluation and management services also would require changes in the CPT descriptors for the evaluation and management codes, a task which is dependent on the AMA. The common features include the three key components in assigning the levels of service, which include history, examination, and medical decision making. However, the medical decision making has been reduced to three levels instead of four, and in the physical examination counting of the items is minimized and references to shading and bullets is eliminated. In addition, a combination of body areas/organ systems and constitutional findings may be used to determine the levels of service, which is an advantage for multisystem examinations since physicians will not have to count numerous bullets or elements. Another advantage, of course, is yet to be released, specialty-specific vignettes for single-organ system examinations. Comparison of 1997 guidelines with new proposed guidelines with the significant differences is shown in Table 5.

PILOT TESTING

The HCFA proposed its pilot testing rather ambitiously (6, 7). However, it appears that physicians remain hesitant to participate in testing of the revised guidelines for the fear of fraud and abuse prosecutions for innocent coding or documentation errors. However, HCFA attempted to assure physicians who participate in pilot testing of draft evaluation and management guidelines that they will be reviewed on a postpayment-basis audit of claims and cash will be rolling. In addition, these claims will not trigger a full-blown audit. Rudolph, a senior technical advisor for the HCFA's Center for Health Plans and Providers, stated, "The HCFA policy will not allow comprehensive audits to be triggered based on evaluation and management service claims filed during the pilot test" (10). In addition, HCFA would not look at claims, either evaluation and management services or nonevaluation in management services, filed prior to the test, based on claim anomalies found during the life of the test. It appears that HCFA is not planning to offer immunity to physicians who participate in the study (9).

IMPLEMENTATION

These proposed guidelines are only draft documents. These should not be used by physicians unless they are participating in the pilot testing. At present, physicians should continue using either 1995 or 1997 guidelines. The description of evaluation and management services guidelines for interventional pain practices is based on 1997 guidelines (1, 7).

CONCLUSION

The evolution of evaluation and management services and various types of guidelines proposed by the HCFA continues. The new proposed guidelines are reported as simpler, easy to use, avoiding confusion and mainly eliminating such wording as *shaded*, *elements*, and *bullets*. However, as we look forward to pilot testing and subsequent modifications, we hope these guidelines will make appropriate documentation easier and clarify a multitude of issues, without fear of fraud and abuse, with increased focus on patient care.

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