WSI
North Dakota Workforce Safety & Insurance

Documentation Policy

Evaluation and Management: Other E/M Services

Effective Date: 01/01/2017	Revised Date: 12/17/2020
Responsible Department: Medical Services	Reviewed Date: 12/17/2020

Introduction
WSI has adopted the *1997 Documentation Guidelines for Evaluation and Management Services* from the Centers for Medicare & Medicaid Services (CMS) for the auditing of Other E/M Services (Hospital Observation, Hospital Inpatient, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home). The purpose of this document is to outline Workforce Safety & Insurance's (WSI) policy regarding the documentation and billing of evaluation and management (E/M) services.

Policy
WSI will audit all E/M service medical records for authentic documentation of the following:

- Chief Complaint
- History of Present Illness
- Review of Systems
- Past, Family, & Social History
- Examination
- Medical Decision Making

WSI will only reimburse the level of E/M service supported by the medical documentation. A billed service not supported by authentic medical documentation will result in a denial or reduction. See Falsified Medical Records Policy for clarification on criteria for authentic medical documentation.

For detailed guidance on WSI's E/M documentation requirements, see Appendix: Evaluation and Management: Other E/M Services.

References
Centers for Medicare & Medicaid Services (CMS). 1997 Documentation Guidelines for Evaluation and Management Services. Retrieved from **https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf**, last accessed 12/17/2020.

AMA CPT® Assistant (August 2004)

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The following guidelines outline the information Workforce Safety & Insurance (WSI) reviews when auditing medical documentation for Other Evaluation and Management (E/M) Services (Hospital Observation, Hospital Inpatient, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home). WSI structured these guidelines based on the *Centers for Medicare & Medicaid Services (CMS) 1997 Documentation Guidelines for Evaluation and Management Services*.

Chief Complaint (CC)
CC is the reason the patient is meeting with the medical provider. Documentation of each visit should include a concise statement describing the symptom(s), problem(s), or condition(s), as stated in the patient's own words e.g., patient complains of upset stomach, aching joints, and fatigue.

History of Present Illness (HPI)
HPI describes the patient's symptoms, evolution of illness, and present status of condition. There are 2 types of HPI:

- **Brief**: 1-3 elements
- **Extended**: at least 4 elements or at least 3 chronic conditions.
    - The visit must necessitate evaluation of the chronic condition(s) and supporting documentation must identify each condition reviewed.

Review of Systems (ROS)
ROS is an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms the patient may be experiencing or has experienced. There are 3 types of ROS:

- **Problem pertinent**: system directly related to the presenting problem
- **Extended**: system directly related to the presenting problem and a limited number (2-9) of additional related systems
- **Complete**: system directly related to the presenting problem and at least 10 additional related systems

For an initial visit, WSI allows a medical provider to reference a patient history form and it must accompany the medical note. In addition, the provider must document they verified the patient history form (if self-reported by the patient) and the date of review.

For a subsequent visit, documentation must include the ROS within the body of the note; WSI allows ROS from previous encounter if it is reviewed and updated or confirmed.

WSI does not accept the following as documentation of a negative finding: negative, unremarkable, or noncontributory. A descriptive response is required for any system.

Past, Family, & Social History (PFSH)
PFSH is a review of the history area directly related to the problem(s) identified in the HPI. For each area reviewed, a descriptive response is required; WSI does not accept documenting negative, not on file, not pertinent or noncontributory.

Documentation of the PFSH must represent the current visit; WSI allows PFSH from a previous encounter if it is reviewed and updated or confirmed.

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Examination
Examination includes assessment of the patient's presenting problem(s) and history based on the provider's clinical judgement. The presenting problem should drive the level of the examination required.

A descriptive response is required for any body area or organ system examined. WSI does not accept documenting abnormal, negative, unremarkable, or noncontributory for negative responses.

Documentation also needs to reflect clear correlation between outcomes of the exam and diagnostic tests ordered.

General multi-system examination content and documentation requirements:
- **Problem Focused Exam**: identification of 1-5 bulleted elements per a minimum of 1 organ system or body area
- **Expanded Problem Focused Exam**: identification of 6 or more bulleted elements per a minimum of 1 organ system or body area
- **Detailed Exam**: identification of at least 2 bulleted elements per a minimum of 6 organ systems or body areas; or a total of 12 bulleted elements in 2 or more organ systems or body areas
- **Comprehensive Exam**: identification of at least 2 bulleted elements per a minimum of 9 organ systems or body areas

Single organ system examination content and documentation requirements:
- **Problem Focused Exam**: identification of 1-5 bulleted elements, whether in a box with a shaded or unshaded border
- **Expanded Problem Focused Exam**: identification of at least 6 bulleted elements, whether in a box with a shaded or unshaded border
- **Detailed Exam**: (other than the eye and psychiatric examinations) identification of at least 12 bulleted elements identified, whether in a box with a shaded or unshaded border
    - Eye and psychiatric exams: identification of at least 9 bulleted elements, whether in a box with a shaded or unshaded border
- **Comprehensive Examination**: identification of all bulleted elements, whether in a shaded or unshaded box, Documentation of every element in each box with a shaded border and at least 1 element in a box with an unshaded border is expected

Medical Decision Making (MDM)
MDM refers to the complexity of establishing a diagnosis and selecting management options as measured by:
- **Number of Diagnoses/Treatment Options**: diagnostic impressions, tentative diagnoses, confirmed diagnoses, and therapeutic options
- **Data Reviewed or Ordered**: amount of complexity of medical records and diagnostic tests ordered and/or reviewed
- **Risk of Complications and/or Morbidity or Mortality**: level of risk related to the patient's presenting problem(s), diagnostic procedures, and possible management options between present visit and next visit

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Time
Time may be considered the controlling factor to determine the level of E/M service when counseling and/or coordination of care constitute greater than 50% of the encounter.

- Counseling is a discussion with a patient and/or family member concerning one or more of the following areas:
    - Diagnostic results, impressions and/or recommended diagnostic studies
    - Prognosis
    - Risks and benefits of management (treatment) options
    - Instructions for management (treatment) and/or follow-up
    - Importance of compliance with chosen management (treatment options)
    - Risk factor reduction
    - Patient and family education
- Documentation requirements
    - Record the total time of the encounter and indicate the time spent in the specific counseling and/or coordination of care activities.
    - The medical note should summarize the content of the counseling that occurred.