EVALUATION AND MANAGEMENT SERVICES Q&A: HOW DOES YOUR MAC INTERPRET THE GUIDELINES?

The following questions and answers were found on Medicare administrative contractors' (MACs) web sites. Table cells were left blank if the answer could not be found. Certain contractors are not included in the table because of a lack of information on their web sites. See the online version of this article at http://www.aafp.org/fpm/2010/0700/p27.html to identify the MAC for your state.

Does documenting "the status of at least three chronic or inactive conditions" meet the requirement for an extended HPI when using the 1995 version of the Medicare's documentation guidelines?	
Medicare's Documentation Guidelines for Evaluation and Management Services	The 1997 version defines an extended HPI as four or more elements of the HPI or the status of three or more chronic or inactive conditions. This definition has not been incorporated into the 1995 version of the guidelines published on the CMS web site, although Medicare's Evaluation and Management Services Guide indicates that this definition is also part of the 1995 guidelines.
Cahaba Government Benefit Administrators	Yes.
First Coast Service Options	No.
Highmark Medicare Services	
National Heritage Insurance Corporation	Yes.
Palmetto GBA	No.
Pinnacle Business Solutions	
TrailBlazer Health Enterprises	
Wisconsin Physicians Health Insurance Corporation	Yes. According to the WPS web site, WPS received clarification from CMS indicating this statement applies to both the 1995 and 1997 versions of the guidelines.
Is it acceptable to document the status of chronic or inactive conditions to meet the requirements for a brief HPI (1-2, since 3 or more has been deemed acceptable for documenting an extended HPI)?	
Medicare's Documentation Guidelines for Evaluation and Management Services	
Cahaba Government Benefit Administrators	No.
First Coast Service Options	No.
Highmark Medicare Services	Yes. "The status of one to two chronic conditions qualifies for an expanded problem-focused HPI." *Editor's note: Since there's technically no such thing as an expanded problem focused HPI, we think the payer means a brief HPI.*
National Heritage Insurance Corporation	Yes. "There is no distinction that states that the status of one or two chronic or inactive conditions would qualify for a brief HPI. However, identifying a problem/condition is sufficient to meet the brief HPI. This qualifies for both the 1995 and 1997 guidelines."
Palmetto GBA	No.
Pinnacle Business Solutions	Yes.
TrailBlazer Health Enterprises	
Wisconsin Physicians Health Insurance Corporation	
Is it acceptable to use summary statements when documenting review of systems (ROS) findings?	
Medicare's Documentation Guidelines for Evaluation and Management Services	Yes. "To correctly document a complete ROS, you must show that you have reviewed at least 10 organ systems, one of which is the system directly related to the problem identified in the HPI. However, you do not have to individually document all the systems reviewed; you only have to document those with a positive or pertinent negative response if you document a review of the remaining systems with a notation like 'all others negative.'"

Cahaba Government Benefit Administrators	Yes.
First Coast Service Options	
Highmark Medicare Services	
National Heritage Insurance Corporation	Yes.
Palmetto GBA	Yes, if the statement makes it clear which systems were found to be negative. "In the CPT manual you will see that there are 14 systems listed, so in this situation stay clear of using '10 other systems negative' etc., because it's not telling us precisely which system. We would look for things like 'all others negative,' 'no other complaint,' etc."
Pinnacle Business Solutions	Yes.
TrailBlazer Health Enterprises	Yes, if the statement makes it clear which systems were found to be negative. "When using 'negative' notation, always identify which systems were queried and found to be 'negative.'"
Wisconsin Physicians Health Insurance Corporation	Yes.
Can a single item count toward both the HPI and ROS? For example, could "shortness of breath" count as an associated sign and symptom in the HPI and respiratory system in the ROS?	
Medicare's Documentation Guidelines for Evaluation and Management Services	
Cahaba Government Benefit Administrators	
First Coast Service Options	
Highmark Medicare Services	Yes. ROS inquiries are questions concerning the system(s) directly related to the problem(s) identified in the HPI. Therefore, it is not considered "double dipping" to use the system(s) addressed in the HPI for ROS credit.
National Heritage Insurance Corporation	
Palmetto GBA	
Pinnacle Business Solutions	Yes. "According to the E/M guidelines an item cannot be used twice within the same section of the history (either HPI, ROS or PFSH), a single item may be used in two separate historical sections. According to CMS documentation guidelines, the use of a single historical item in both HPI and ROS is recognized as an acceptable practice." *Editor's note: We were unable to verify this in Medicare's documentation guidelines.*
TrailBlazer Health Enterprises	
Wisconsin Physicians Health Insurance Corporation	Yes, "in rare circumstances." "A clearly documented medical record would prevent the need to 'double-dip' for HPI and ROS, but WPS Medicare, in rare circumstances, could accept counting one statement in both areas if necessary."
If the physician documents "unchanged from last visit," will he receive credit for reviewing the last visit information?	
Medicare's Documentation Guidelines for Evaluation and Management Services	Yes. "An ROS and/or a PFSH obtained during an earlier encounter does not need to be rerecorded if there is evidence that the physician reviewed and updated the previous information. ... 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."

Cahaba Government Benefit Administrators	
First Coast Service Options	
Highmark Medicare Services	No. "Credit may be taken only if the physician includes the documentation from the previous visit. Otherwise, the reviewer would not know what was the same or unchanged from the previous visit."
National Heritage Insurance Corporation	
Palmetto GBA	
Pinnacle Business Solutions	
TrailBlazer Health Enterprises	
Wisconsin Physicians Health Insurance Corporation	

Can we combine the number of "organ systems" and "body areas" when counting the number required for a comprehensive exam according to the 1995 version of the guidelines?

Medicare's Documentation Guidelines for Evaluation and Management Services	No. "The medical record for a general multisystem examination should include findings about 8 or more of the 12 organ systems."
Cahaba Government Benefit Administrators	
First Coast Service Options	No. "Eight organ systems must be examined in order to have a comprehensive exam using the 1995 guidelines. If body areas are examined and counted, they must be over and above the eight organ systems."
Highmark Medicare Services	No. "The exam section of the 1995 score sheet is divided into body areas and organ systems. The CPT manual recognizes seven body areas and 12 organ systems. Depending on documentation in the medical record you can use either the body areas or the organ systems. If you combined the body areas and organ systems you would be giving credit twice, which would be incorrect when determining the final score for the exam section of the score sheet."
National Heritage Insurance Corporation	No. "Eight or more organ systems, not body areas."
Palmetto GBA	
Pinnacle Business Solutions	
TrailBlazer Health Enterprises	
Wisconsin Physicians Health Insurance Corporation	

Do you require that the level of service coded never be higher than the level of medical decision making?

Medicare's Documentation Guidelines for Evaluation and Management Services	
Cahaba Government Benefit Administrators	No. "CPT 99215 is allowed with two of three elements. We look for medical necessity of services and the provider's amount of work performed." *Editor's note: This answer uses 99215 as an example but the same applies to all established patient codes.*
First Coast Service Options	
Highmark Medicare Services	

National Heritage Insurance Corporation	NHIC's web site offers contradictory answers to this question. First answer: "NHIC accepts two of the three key components and MDM does not have to be one of them." Second answer: "At least two of three key components must be met: • One is the level of decision making. • If the MDM is lower than what is required for that code, the service will be re-coded. • Even if the history and exam meet or exceed the requirements for lower level of service, recoding would be based on condition of the patient."
Palmetto GBA	
Pinnacle Business Solutions	Pinnacle's web site offers contradictory answers to this question. First answer: "Neither the 1995 nor the 1997 E/M documentation guidelines state more emphasis should be placed on MDM. The CPT manual requires all three elements (history, examination, and medical decision making) for new or initial patient encounters and two of the three key elements for established or follow-up patient encounters. The CPT manual does not state more emphasis should be placed on MDM when determining the level of care given to the patient." Second answer: "Medical review places the most significant emphasis on the level of MDM documented and required by the condition of the patient. For example, if 99223 is billed with a comprehensive history, comprehensive examination and moderate level of MDM, this would be recoded to 99222 to reflect the level of decision making and level of history and exam that would exceed those required for 99222."
TrailBlazer Health Enterprises	No. "The components are equally weighted. However, coding for medical necessity often relies more heavily on MDM than on either of the other key components."
Wisconsin Physicians Health Insurance Corporation	
What is the role of ancillary personnel in documenting patient history?	
Medicare's Documentation Guidelines for Evaluation and Management Services	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.
Cahaba Government Benefit Administrators	
First Coast Service Options	
Highmark Medicare Services	
National Heritage Insurance Corporation	
Palmetto GBA	"Ancillary staff may only document the ROS, PFSH and/or vital signs. If they document these, these three areas must be reviewed by the physician or NPP and the physician or NPP must write a note or statement saying that they've reviewed it. Previously, we've said that ancillary staff could document and we still are basically saying that they can document the HPI. However, ... the physician providing this E/M service must consider it preliminary and needs to document that he or she explored the HPI in more detail."

Pinnacle Business Solutions	
TrailBlazer Health Enterprises	"Nurses and other ancillary staff who are not licensed by the state as qualified NPPs may gather information about the HPI, may perform/ record the constitutional portion of the physical exam, and may perform/record the PFSH and ROS if doing so is legally within their scope of work under state laws. However, for coding E/M services reported to Medicare for payment, only HPI, physical examination (PE) (other than constitutional system) and MDM work performed by the physician is counted. The physician must perform the work of the HPI in this case."
Wisconsin Physicians Health Insurance Corporation	"WPS Medicare will allow the CC when recorded by ancillary staff. However, the physician must validate the CC in the documentation. The 1995 and the 1997 documentation guidelines indicate ancillary staff may obtain the ROS and PFSH but they do not indicate the ancillary staff can obtain the HPI."