



## EVALUATION AND MANAGEMENT (E&M) PROGRAM CLAIM & CODE REVIEW

### **OVERVIEW**

The Evaluation and Management (E&M) Program is part of the Third-Party Claim and Code Review Program. We contract with a vendor to review coding for E&M services. For select providers, our vendor will evaluate the appropriateness of levels 4 and 5 E&M codes to determine whether the level of service billed matches the intensity of the service and the severity of the illness. The edits are not clinical, they are based on external coding guidelines. Our vendor uses certified coders who review the claim billed and the member and provider claim history to make the edit decision.

### **PURPOSE**

The Program evaluates the appropriateness of levels 4 and 5 E&M codes to determine whether the level of service billed correlates to the intensity of the service and the severity of the illness.

### **APPLICATION**

E&M services may be billed with different levels of service depending on:

- History
- Physical examination
- Medical decision making
- Counseling
- Coordination of care
- The nature of the problem
- Time

We review Level 4 and 5 New and Established Patients E&M Codes for Office, Outpatient, Consultation and Ophthalmological Services in the context of these guidelines.

The applicable places-of-service include:

- In Office
- Off Campus - Outpatient Hospital
- Urgent Care Facility
- Inpatient Hospital
- On Campus - Outpatient Hospital
- Emergency Room – Hospital

### **PROCESS**

We follow national guidelines for coding and documenting E&M services. Both CMS and the American Medical Association (AMA) have guidelines that provide specific requirements for new and established patient office visits and consultations. CMS and AMA guidelines include:

- The medical record should clearly reflect the chief complaint.
- Review of Systems and Past, Family, and/or Social History can be a form that is subject to updates.
- Generally, decision making with respect to a diagnosed problem is easier than that for an identified, undiagnosed problem.
- Problems that are improving or resolving are usually less complex than those that are worsening or failing to change as expected.
- The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses.
- The assessment of the level of risk is affected by the nature of the event under consideration.
- Office and other outpatient Service (99202-99215) include a medically appropriate history and physical examination, when performed.
  - Use best clinical judgement
  - Nature and extent of history and exam will not impact the level of service
- Appropriate Level of Service will be based on one of the following:
  - Medical decision making
  - Number and Complexity of Problems Addressed at the Encounter
  - Amount and/or Complexity of Data to be Reviewed and Analyzed
  - Risk of Complications and/or Morbidity or Mortality of Patient Management decisions
  - made during the visit.
  - Total time (counseling and coordination of care)
  - Defined as total time spent on a patient's care on the date of encounter. Includes both face to face service and non-face to face services
  - Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. The documentation in the medical record should support the CPT and ICD codes reported on the health insurance claim form.

**More information on CMS and AMA guidelines is available at:**

CMS Final Rule

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf>

AMA website

<https://www.ama-assn.org/practice-management/cpt/implementing-cpt-evaluation-and-management-em-revisions>

CMS-E/M Fact Sheet

<https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation->

and-management-em-visits-fact-sheet.pdf

AAPC

<https://www.aapc.com/codes/em-calculator-2021/index>

### **What to do if you disagree with an edit.**

If you don't agree with an edit, can follow the standard process to request reconsideration.

We recommend including a written request with medical records/notes through the following:

- Address on the EOB.
- Using the "Contact us" functionality through our provider portal on Availity.
- If your claim edit is not overturned after reconsideration, you'll receive a notice of the decision with your any further appeal right.
- Unless your contract has special dispute provisions, you should follow the standard timeframes to request a claim reconsideration or appeal.

**You can learn more about our provider claim dispute processes on Aetna.com:**

<https://www.aetna.com/health-care-professionals/disputes-appeals/disputesappeals-overview.html>

For additional assistance and guidance, you can also call the provider service center at **1-888-632-3862**.

### **METHODOLOGY**

The methodology for application of the Program depends on the market. For New York, our vendor uses certified coders who review the claim billed and the member and provider claim history to make the edit decision.

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