Evaluation and Management (E/M) Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

This policy is intended to address Evaluation and Management (E/M) services.

The E/M coding section of the CPT® book is divided into broad categories with further sub-categories which describe various E/M service classifications.

The classification of the E/M service is important because the nature of the work varies by type of service, place of service, the patient's medical status, and other code criteria, along with the amount of provider work and documentation required. The key components appear in the descriptors for most basic E/M codes and many code categories describe increasing levels of complexity.

This reimbursement policy explains when medical records may be requested to ensure that the appropriate level of CPT E/M code is reimbursed based on the health care services provided. The code(s) reported by physicians or other health care professionals should best represent the services provided based on the American Medical Association (AMA) and CMS documentation guidelines.

Reimbursement Guidelines

Evaluation and Management E/M Documentation Requirements

In alignment with Office and Outpatient Evaluation and Management Coding Guidelines (99202-99205, 99211-99215) changes that were effective January 1, 2021, the CPT codes section for Non-Office E/M Visits (99221-99223, 99231-99239), Consultations codes (99242-99245, 99252-99255), Emergency Department Services codes (99281-99285), Nursing Facility Services codes (99304-99310, 99315, 99316), Home or Residence Services codes (99341,99342, 99344, 99345, 99347-99350) were revised January 1, 2023.

Except for CPT codes 99281-99285, providers may choose the appropriate E/M level of care based on either Time or Medical Decision Making (MDM). CPT codes 99281-99285 use only MDM to determine level of care.

Selecting the Level of Service Based on Time

Time documentation criteria for time spent face-to-face or non-face-to-face may include, but not limited to:

- Examination/Evaluation
- Counseling/Education
- Prep time for patient history/test reviews
- Documentation/Interpretation
- Care Coordination/Referring and Communication with other health care providers
- Orders for tests, procedures, and medication

Time documentation criteria for time spent face-to-face or non-face-to-face may not include:

- Time spent by clinical staff
- Patient wait time for physician or other health care providers
- Additional distinct service procedures provided the same day as the evaluation and management service

Selecting the Level of Services Based on Medical Decision Making (MDM)

1. Number and complexity of problem(s) addressed
2. Amount and/or complexity of data reviewed and analyzed
   - Orders for, and interpretation of data from a test or image cannot be included when determining the E/M level of service if the test or image interpretation is billed separately
3. Risk of complications and/or morbidity or mortality of patient management
   - UHC will continue to use the definitions from the CMS Manual System's Pub 100 Medicare Claims

Processing, 40.1 - Definition of a Global Surgical Package, "Codes with “090” in Field 16 are major surgeries. Codes with “000” or “010” are either minor surgical procedures or endoscopies."

When determining the level of MDM, two of the three elements for that level must be met or exceeded.

Additional information regarding the code selection based on Time or MDM and the requirements for each can be found in the most current edition of the American Medical Association CPT codebook.

Note: A providers’ level of care escalation data and parenteral narcotic use data may be compared to their historical data and to peer data.

New Patient or Established Patient Status for Emergency Department Visits:
Time is not a descriptive component for emergency department E/M levels of service. Providers must use CPT codes 99281-99285 for emergency department visits for both established patients and new patients for the emergency department visit. (Note: Providers or other health care professionals who are requested to serve as a consult should utilize the appropriate E/M code administered.)

Note: CPT codes 99281-99285 must only be submitted for services provided in an emergency department as defined by AMA CPT; “as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day,” and “organized based facility” includes hospital owned free-standing emergency departments.

Providers may experience adjustments to, or denials of the office visit or other outpatient E/M code or emergency department E/M code reported if the documentation does not support the E/M level submitted. The provider may resubmit the claim with a revised E/M code for denied claims.

Evaluation and Management Procedure Code List

99202	99203	99204	99205	99211	99212	99213	99214	99215	99221
99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99242	99243	99244	99245	99252	99253	99254	99255	99281	99282
99283	99284	99285	99288	99291	99292	99304	99305	99306	99307
99308	99309	99310	99315	99316	99341	99342	99344	99345	99347
99348	99349	99350							

Definitions	
Encounter	Interaction between a covered member and a health care provider for which evaluation and management service or other service(s) are rendered and results in a claim submission

Questions and Answers	
1	**Q:** When a separate written report for diagnostic services (i.e., 93000, 93005, 93010) is prepared by the same provider or provider group performing the E/M service, should this be counted in determining the level of care? **A:** No. Per AMA guidelines: When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making or the reported time calculation when selecting a level of office or other outpatient E/M service.
2	**Q:** Will UnitedHealthcare require medical records for all reported E/M services?

	A: No. UnitedHealthcare may request medical records when the data indicates a physician or other health care professional has a billing pattern that deviates significantly from their peers, or claim attributes indicate possible billing errors.
3	**Q:** How does the policy apply to Electronic Health Record use? **A:** While there is no prohibition on the use of proprietary templates, documentation from either an electronic health record (EHR) or hard-copy that appears to be cloned (selected information from one source and replicated in another location by copy-paste methods) from another record, including but not limited to history of present illness (HPC), exam, and MDM, would not be acceptable documentation to support the claim as billed. The documentation guidelines apply to any medical record produced.
4	**Q:** The services provided to the patient meet the time requirement of 24 minutes for code 99213 but does not meet the required 2 out of 3 MDM elements. Is it appropriate to select the appropriate CPT code based on time? **A:** Yes. The selection of the appropriate E/M code can be determined by either utilizing the time or MDM requirement except for CPT codes 99281-99285.

Resources

American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System, and other CMS publications and

Novitas Solutions – Medicare Part B: "Evaluation & Management Services: Medical Decision Making: https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005056

History

1/1/2023	Policy Version Change Updated Reimbursement Guidelines, Code List, Definitions, Questions and Answers, and Resources
6/7/2021	Policy Version Change Attachments Section: Removed attachment(s) and converted to table(s)
1/1/2021	Policy Verbiage Change Sections: Overview, Reimbursement Guidelines, Questions and Answers, Attachments
5/1/2020	Annual Policy Version Change (No New Version)
4/1/2019	Annual Policy Version Change (No New Version)
10/1/2018	Policy Version Change: Policy Clarification: Reimbursement Guidelines Section
9/1/2016	Policy Publication
4/21/2016	Policy Approved by the Payment Policy Oversight Committee

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