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 Community Plan reimbursement policies uses 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 Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, 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 Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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 UnitedHealthcare Community Plan Medicaid product. 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 and 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.

Table of Contents

Policy

Overview

This policy is intended to address Evaluation and Management (E/M) services reported using Current Procedural Terminology (CPT®) codes 99201-99350. Each code contains three (3) "key" components: history, examination and medical decision making, which are used as a basis for selecting a level of E/M code that best describes the service rendered to the patient.

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.

CPT provides guidelines for the appropriate selection of E/M codes and the required documentation. In addition, CMS published E/M documentation guidelines in 1995 and 1997 for each of the key components of E/M services.

The documentation of the three components (history, examination and medical decision making) depends on clinical judgment of the provider and the nature of the presenting problem(s). Each of these three components has different levels of complexity.

This policy describes when E/M records may be requested and the UnitedHealthcare methodology used for medical record review under this policy.

Reimbursement Guidelines

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 AMA and CMS documentation guidelines. Refer to the resource section below for guidance on documenting and reporting E/M services accurately.

UnitedHealthcare uses an Optum proprietary scoring tool based on the instructions in the 1995 and 1997 CMD documentation guidelines. Medical records are requested when the data shows a physician or other health care professional has a billing pattern that deviates significantly from their peers.

The medical record review process takes into consideration CMS documentation guidelines. Based on the record review points are assigned in accordance with the documented medical record. For example, medical decision making is one component of the scoring tool as follows:

A. Number of Diagnoses and Management Options	Points Assigned
Self-Limiting or minor Problems (stable, improved or worsening)	1
Established Problem – stable improved	1
Established Problem – Worsening	2
New Problem – No Additional Work-up Planned.	3
New Problem – Additional Work-up Planned	4

Additional Work-up Planned is an element of review which includes a number of diagnoses and management options. The Additional Work-up Planned element contributes to indicating the complexity of a patient based on the clinician's utilization of diagnostic tests.

The Additional Work-Up Planned is a key element for a highly complex E/M service and constitutes any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making.

An example of Additional Work-Up Planned is when the provider of service contacts the patient's physician or other specialist with recommendations for additional follow-up care and the discussion is documented in the medical records. A simple instruction to the patient to contact their primary physician does not constitute Additional Work-up Planned.

The examples below are based on a record review assessment and further illustrate the medical decision making component scoring above.

Office E/M documentation:
  (1) **Established Problem- Worsening:** An established patient sees his/her gastroenterologist due to worsening of his/her Crohn's disease. The physician provides an E/M service and adjusts the patient's medication. Two (2) points would be assigned for Established Problem- Worsening score.
  (2) **New Problem-Additional Work-up planned:** The patient presented to his/her new family practitioner with symptoms requiring additional tests and/or a referral to a specialist. In addition the family practitioner contacts the specialist directly to discuss the patient's case. Four (4) points would be assigned for New Problem-Additional Work-up Planned score.

Emergency Room/Department E/M documentation:
  (1) **New Problem- No Additional Work-up Planned:** A patient presents with a low grade fever and pharyngitis. An examination is provided and the patient is sent home with a prescription and instructed to follow-up with their primary care physician as needed. Three (3) points would be assigned for New Problem- No Additional Work-up Planned score.
  (2) **New Problem – Additional Work-up Planned:** A patient presents with abdominal pain and hematuria. The ER/ED physician (or staff) schedules an outpatient MRI and/or communicates directly with the patient's primary physician or other specialist after discharge from the ER/ED and the discussion has been documented in the medical record. Four (4) points for Additional Work-up Planned would be scored. Credit is not given for Additional Work-up Planned if the clinical testing/consultation occurred during the ER/ED Encounter or in the instance when the patient is instructed to contact their primary physician. This application is consistent with a more complex E/M code level.

Providers may experience adjustments to or denials of the 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.

Definitions	
Additional Work-up Planned	Any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making.
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 tests/studies is prepared by the same individual performing the E/M service in an ER/ED place of service, should this be considered as a factor in the E/M code selection? **A:** No. Any specifically identifiable procedure reported separately from the E/M service should not be considered in the selection of E/M service level reported. For example, a patient presents to the ER/ED with chest pain and an EKG is performed. The EKG is normal; the attending provider determines that the patient has angina and provides a prescription. This would NOT be considered Additional Work-Up Planned because the test was performed and a diagnosis was made during the ER/ED Encounter. If another provider other than the attending provider (such as a cardiologist or radiologist) bills the CPT code for the interpretation, then 2 points are scored because the attending provider is not billing for the interpretation separately.

2	**Q:** Will UnitedHealthcare require medical records for all reported E/M services? **A:** No. UnitedHealthcare requests medical records **when the data indicates a physician or other health care professional has a billing pattern that deviates significantly from their peers.**
3	**Q:** What if the Encounter doesn't require Additional Work-up Planned but does require high complexity medical decision making (MDM)? **A:** The provider may submit medical records for review. Consideration will be given to the medical record provided. The Additional Work-up is a component of the number of diagnoses and management options. There are two other elements – amount/complexity of data and the table of risk which contribute to the medical decision making element. CPT also notes that when counseling and/or coordination of care dominates more than 50% of the encounter with the patient and/or family, then time shall be considered the key or controlling factor to qualify for a particular level of E/M services.
4	**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.

Attachments:	
📎	Evaluation and Management Procedure Codes

Resources
Individual state Medicaid regulations, manuals & fee schedules American Medical Association*, Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services Medicare Learning Network Bulletin – Evaluation and Management Services – ICN006764 – August 2016. • https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf   Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services including but not limited to 1995/1997 guidelines. • 1995 Guidelines: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf • 1997 Guidelines: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf   Novitas Solutions – Medicare Part B: "Evaluation & Management Services: Medical Decision Making https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005056

History	
04/24/2020	Annual Anniversary Policy Version Change Policy: Removed all files and references to Louisiana contained in the body of the policy,

	information has been moved to the "Louisiana Only" policy Questions and Answers: #4 removed referenced link Resources: Updated Novitas Solutions Link History: Entries prior to 1/1/2018 archived
1/01/2019	Annual Policy Version Change
10/1/2018	Policy Version Change Policy Clarification: Reimbursement Guidelines Section
7/11/2018	Policy Approval Date and Version Change
1/1/2018	Annual Policy Version Change
9/1/2016 – 12/31/2016	Policy implemented by UnitedHealthcare Community & State
4/21/2016	Policy approved by the Payment Policy Oversight Committee