Priority Health	BILLING POLICY No. 010
EVALUATION AND MANAGEMENT	
Date of origin: April 2024	**Review dates: None yet recorded**

APPLIES TO
This policy applies to all plans.

DEFINITION
This policy addresses Evaluation and Management (E/M) services within the E/M coding section of the CPT® book.

POLICY SPECIFIC GUIDELINES

General guidelines
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 policy identifies that 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 providers should accurately represent the services provided based on the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) documentation guidelines. Medical necessity of a service is the encompassing element for payment in addition to the individual requirements of an E/M visit code. Documentation should support the level of service reported.

Overcoding
Overcoding is defined as reporting procedure codes at higher level than what is warranted by the clinical documentation.

Documentation should support the medical necessity and diagnosis reported. General principles of E/M written by CMS dictate that providers report diagnosis and treatment codes on the claim form that are consistent with the documentation in the medical record. Claims billed for E/M services not supported by documentation will be denied.

Providers may choose the appropriate E/M level of care based on either Time or Medical Decision Making (MDM).

1. 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 are 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 E/M service

2. **Selecting the level of services based on Medical Decision Making (MDM)**
   - Number and complexity of problem(s) addressed during this visit
   - Amount and 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
   - Risk of complications and/or morbidity or mortality of patient management

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 Evaluation and Management (E/M) Services Guidelines of the American Medical Association CPT codebook.

Modifier 25

Modifier 25 is used to describe a "significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service."

Review our policy regarding use of modifier 25.

New vs. established patient

Review our guidelines on reporting new vs. established patient E/M codes.

Global surgical packages

Priority Health will edit claims for E/M services performed within global period for applicable services. All applicable global surgical modifiers should be utilized when supported by documentation, prior to claim submission. Review our global surgical packages information. There are also global surgery modifiers that should be considered. Review our modifier page for more information.

Multiple visits per day

Priority Health will reimburse one E/M visit per group and specialty per day. If both preventive and problem-oriented services are billed, documentation must support that both services were provided in their entirety as significant and separately identifiable services. Then report the problem-oriented E/M service with modifier 25. Review our modifier page for more information.

Emergency department visits

Time is not a descriptive component for emergency department (ED) E/M levels of service. Providers must use CPT codes 99281-99285 for ED visits for new and established patients. CPT codes 99281-99285 must only be submitted for services provided in an ED 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 hospital-based facility” includes hospital owned free-standing EDs. Providers may experience adjustments to or denials of the office visit or other outpatient E/M code or ED 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.

Find more information on reporting two E/M visits in the ED on the same date of service (DOS).

Psychological E/M services

Psychological E/M services are performed to address difficulties associated with an acute or chronic illness, prevent a physical illness or disability and maintain health that do not meet criteria for a psychiatric diagnosis. Find details for reporting these E/M services.

REFERENCES

CPT Evaluation and Management (AMA)

CHANGE / REVIEW HISTORY

Date	Revisions made