PAYMENT REIMBURSEMENT POLICY

Title: PRP-18 Evaluation and Management Services

Category: Compliance

Effective Date: 03/02/2022

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy applies to all network and non-network physicians and other qualified health care professionals, including but not limited to percent of charge contract physicians and other qualified health care professionals. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. PHP may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but which are covered by the Plan to support covered benefits available through one of the Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms will take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

This policy applies to Evaluation and Management (E/M) services as indicated in the Evaluation and Management Services section of the Current Procedural Terminology (CPT®) coding manual. The Health Plan applies code edits and performs claim audits based on industry coding rules and guidelines. Industry sources include but are not limited to Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), American Medical Association (AMA), Complete Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS®), American Society of Anesthesiology (ASA), and coding guidelines developed by national medical specialty societies. Code selection of E/M services must represent the services provided and documented based on AMA and CMS documentation guidelines for the date of service billed. Providers are responsible for submitting accurate claims and the maintenance of complete and accurate documentation to support billing.

3.0 Coding and Billing:

Consultations.

The Health Plan follows CMS guidelines regarding consultation coding. The Health Plan does not reimburse the billing of outpatient (99241-99245) or inpatient (99251-99255) CPT consultation codes. Providers should instead report the service with the E/M code that represents the location, patient status (new/established) and complexity of visit performed.

Incidental Services.

Incidental services are minor services provided incident to another professional service and commonly included in the primary service used in the course of diagnosis or treatment of injury or illness. For example, urinalysis procedures (81002 or 81003); when these services are billed in conjunction with any E/M service, they are not separately reimbursed.

Application of modifier 25 to the E/M service or a modifier 59 to the urinalysis procedure, on the same day, for the same member, by the same provider, on the same or different claims will not override the edit.

Multiple E/M Services - Same Date of Service.

The Health Plan follows the CMS guidelines regarding same day E/M services. When physicians are of the same group practice and same specialty, services must be bill and receive reimbursement as if they were a single physician. When more than one E/M service is performed on the same date of service, only one E/M service may be reported unless the E/M services are for an unrelated diagnosis/treatment. When more than one encounter for related services occurs on the same date of service, the physicians should select a level of service representative of the combined evaluation and management services. Documentation for both encounters should be made available if requested for claim review.

New vs Established Patient Visits.

A patient is consider "new" if the individual has not received any professional services rendered by physicians or other qualified health care professionals that may bill for evaluation and management services and are of the same specialty, subspecialty, and group practice within the past three years. A patient is considered established, if the individual has received any professional services rendered by physicians or other qualified health care professionals that may bill for evaluation and management services and are of the same specialty, subspecialty, and group practice within the past three years. If a physician or other qualified health care professional rounds at a facility, that point of care is taken into consideration and following encounters with that physician and other qualified health care professionals of the same specialty, subspecialty, and group practice will be considered established encounters following that encounter.

Preventive Visit & Problem Orientated Visit- Same Date of Service.

The Health Plan reimburses for both a preventive and problem-orientated visit for the same date of service when documentation supports the evaluation and management of a separately identifiable problem addressed during the same encounter as the preventive service. Documentation should support the additional work and modifier -25 should be applied to the E/M service.

For example, patient presents for annual well visit and during the visit mentions they have been experiencing throat pain for several days. Provider performs additional work up, including rapid strep test, and provides care plan for strep. Significant additional work up is documented and supports the billing of a problem-orientated visit along with the preventive well visit.

Prolonged E/M Services.

The Health Plan reimburses for prolonged services when appropriately billed and supported in documentation.

1. As of January 1, 2021, CPT code 99417 replaces CPT codes 99354 and 99355.
    - CPT 99417 is reportable only with level 5 visits (CPT codes 99205 & 99215).
2. Documented time must exceed the minimum time for primary E/M service.
3. Time alone must be the basis for coding.

Significant and Separately Reportable Services.

Modifier -25 defines a significant, separately identifiable Evaluation and Management (E/M) service by the same physician or other qualified health care profession on the same day of a procedure or other service. This includes any physician in the same group practice and of the same specialty. Documentation must support an additional work with a level of effort beyond what is normally performed as part of the E/M service.

Modifier -25 is not appropriate for E/M codes that are explicitly for new patient only (CPTs 92002, 92004, 99201-99205, 99321-99323 and 99341-99345). These codes are listed as new patient codes and are automatically excluded from global surgery package edit. They are reimbursed separately from surgical procedure and no modifier is required if visit meets significant and separately identifiable guidelines.

2021 Changes -Outpatient Services (99201-99215).

CPT codes impacted: 99201-99215.

The History and Exam portions of the E/M office and outpatient visit levels will no longer be scored as they have been prior to January 1, 2021. New prolonged service CPT code 99417 (see prolonged service section). Coding selection is established based on time or medical decision making (MDM). These changes do not affect the standards of documentation. Documentation should still include details of history and exam to support MDM.

If code selection is applied based on time, the total time attributed to the patient on the date of service must be clearly documented in the medical record. As of January 1, 2021, time represents total provider time spent on the date of service and may include the following when documented and not otherwise reported separately.

- Preparing to see the patient (e.g., review of tests).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling and educating the patient/family/caregiver.
- Ordering medications, tests or procedures.
- Referring and communicating with other health care professionals.
- Documenting clinical information in the electronic or other health record.
- Independently interpreting results and communicating results to the patient/family/caregiver.
- Care coordination.

4.0 Documentation Requirements:

Documentation of services, including E/M services, must follow the general principles of medical record-keeping based on CMS and Physician's Health Plan Guidelines. Documentation requirements may vary based on the services provided.

Some key documentation principles to follow are:

- Clearly document medical necessity to support services rendered
- Documentation must be complete and legible.
- Avoid handwritten acronyms that may not be industry standard or shorthand terms used by the office and may be unclear to an auditor.
- Avoid copy and paste or autofill templates.
- Avoid Check Boxes that don't provide full and accurate details.
- Documentation of E/M encounter should include all applicable details that support the level of care billed including but not limited to:
- Problem(s) addressed (Chief Complaint).
- Nature and complexity of problems.

- Social determinants of health.
- History and Exam relevant to current problem(s) addressed.
- Medication management.
- State of illness.
- Tests ordered and/or reviewed.
- Care Plan.

5.0 Verification of Compliance:

Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy.

E/M services may be audited. An audit is commonly initiated when the data indicate an outlier such as significant deviation from the median billing of their peers. The audit process includes review of medical record in accordance with CMS guidelines and Health Plan policies. For dates of service prior to January 1, 2021, Health Plan auditors are applying 1995/1997 E/M guidelines. For dates of service January 1, 2021 and after; Health Plan auditors are applying MDM assessment, including review of number and complexity of problems addressed, reviewed/analyzed data, and risk level; or Time assessment based on documented and supported total time related to the encounter.

6.0 Terms & Definitions:

Additional Work-Up. Testing, consultations, referrals or other services beyond the current encounter organized and performed to aid the provider in medical decision making.

Chief Complaint (CC). The chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the current encounter.

Encounter. The encounter refers to the interaction between a patient and healthcare provider(s) for the purpose of providing healthcare service(s) or assessing the health status of a patient.

History of Present Illness (HPI). The HPI describes the development of the patient's current illness including initial sign/symptom or changes from previous encounter to current.

Medical Decision Making (MDM). MDM reflects the nature of the patient's presenting problem, and overall complexity of establishing a diagnosis and/or selecting a management option. During the MDM portion of an encounter the provider assesses the patient, advises the patient and assists the patient in management of health status resulting in an individual plan of care.

Medically Appropriate. Services defined as health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms that meet accepted standards of medicine.

Medically Necessary**.** Coverage of health care services and supplies that we determine to be medically appropriate per Health Plan medical policy and nationally recognized guidelines, and are:

- Not Experimental or Investigational Services.
- Necessary to meet the basic health needs of the Covered Person.
- Delivered in the most cost-efficient manner and type of setting that is appropriate.

- Consistent in type, amount, frequency, level, setting, and duration of treatment with scientifically based guidelines that are accepted by Health Plan.
- Consistent with the diagnosis of the condition.
- Not done for reasons of convenience.
- Demonstrated through current peer-reviewed medical literature to be safe and effective.

Even if you have already received treatment or services, or even if your health care provider has determined that a particular health care service or supply is medically appropriate, it does not mean that the procedure or treatment is a Covered Health Service under the Policy.

Patient Family. Social History (PFSH). The PFSH includes a review of three areas of patient information:

- Patient History, the patient's past illnesses, operations, injuries, medications, allergies and/or treatments.
- Family History, review of the patient's family medical history including disease which may be hereditary or place the patient at risk.
- Social History, age-appropriate review of past and current activities (i.e. job, marriage, exercise, drug/alcohol usage etc.).

Problem Addressed. To qualify as a problem the documentation must indicate that the provider evaluated or treated the problem during the encounter. This includes consideration of testing and treatment ruled out due to risk involved or patient decision.

Prolonged Services. Services performed beyond the threshold time for the evaluation and management service the physician or qualified health provider provided during the encounter.

Review of Systems (ROS). The ROS is an inventory of the body systems that is obtained through a series of questions in order to identify signs and/or symptoms, which the patient may be experiencing.

Risk. Relates to the probability of occurrence. As it relates to E/M coding, high probability of a minor adverse effect may be low risk, depending on the case. The terms high, medium, low, and minimal risk are meant to reflect the common meanings used by clinicians. For MDM, risk should be based on the consequences of the addressed problems when they're appropriately treated. Risk also comes into play for MDM when deciding whether to begin further testing, treatment, or hospitalization.

Self-limited or Minor Problem. A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. Relevant to straightforward MDM.

Separately Identifiable E/M. Substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.

Social Determinants of Health. Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Time. As it relates to E/M code selection; minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service. Total does not include time spent on services that are separately billable.

7.0 References, Citations, Resources & Associated Documents:

1. CMS Transmittal 1764.
2. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services including but not limited to 1995/1997 guidelines.

3. 1995 Guidelines: https://www.cms.gov
4. Current Procedural Terminology book, available from the American Medical Association.
5. Medicare Claims Processing Manual (Pub. 100-4).
6. American Medical Association https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf.

8.0 Revision History:

Revision Date	Reason for Revision
11/21	Annual review, CCSC approved on 12/07/2021, removed a broken website link.