University of Michigan Health Plan

PAYMENT REIMBURSEMENT POLICY

Title: PRP-18 Evaluation and Management Services

Category: UMHP_PAYMENT REIMBURSEMENT (PR)

Effective Date: 10/1/2024

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), the National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. UM Health Plan 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 the Centers for Medicare and Medicaid Services (CMS), the 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:

AMA Changes

2023 Changes

The AMA CPT® Editorial Panel approved additional coding and documentation revisions to include hospital inpatient, hospital observation, consultation, emergency department, nursing facility, domiciliary, and rest home E/M services effective January 1, 2023. Therefore the 2021 AMA Documentation Guidelines will now apply to the full CPT® E/M Section.

2024 Changes

- The time ‘range” in minutes will be removed from the office and other outpatient visit codes (99202-99205, 99212-99215). The ranges will be replaced with threshold times. To report the E/M level, the minimum total time on the date of the encounter must be met or exceeded.
- A clear definition set for “Substantive portion” in split/shared E/M visits.

- Introduction of guidelines for CPT® codes 99234-99236 when patient's stay spans two calendar days.
- The hospital inpatient and observation care services and the nursing facility services are “per day” services. When multiple visits occur over the course of a single calendar date in the same setting, a single service is reported.
- Revision to nursing facility care CPT® codes 99306 and 99307. Time thresholds increased by five minutes.

E/M Standards

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 the 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. Incidental services are not separately reimbursed.

Medical Decision Making (MDM) Code Selection

An E/M level may be selected based on Time or Medical Decision Making. When selecting an E/M level based on MDM, the key elements to consider are Problem, Data, and Risk. The condition(s) evaluated and/or treated during the current encounter and the complexity of problems, data, and risk addressed determine the level of Medical Decision Making (MDM). Based on the complexity and elements of Problem, Data, and Risk, the medical decision-making is deemed either Straightforward with minimal risk of morbidity from additional diagnostic testing or treatment, Low with a low risk of morbidity from additional diagnostic testing or treatment, Moderate with an average risk of morbidity from additional diagnostic testing or treatment, or High, with a more than average risk of morbidity from additional diagnostic testing or treatment. Documentation must support the selection of the MDM level.

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 billed 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 considered “new” if the individual has not received any professional services rendered by physicians or other qualified health care professionals who may bill for evaluation and management services and are of the same specialty or subspecialty who belongs to the same 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 who may bill for evaluation and management services and are of the same specialty or subspecialty who belongs to the same 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 or subspecialty and group practice will be considered established encounters following that encounter.

For urgent care centers that may have providers on staff of varying specialties, only one new patient visit may be billed by the group for patients seen within the past three years.

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

Preventive medicine E/M services (CPT codes 99381-99397) include an age and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and ordering laboratory/diagnostic procedures. The encounter may consist of a complete physical exam, screenings (e.g., blood pressure, glucose, cholesterol, weight, temperature, pulse, prostrate, colorectal), pelvic exam, pap smear, sexually transmitted disease testing, a thorough review of general health and well-being, immunization review and update, and developmental screenings. These visits are for the purpose of preventive care, and they serve to promote wellness and the prevention of disease.

Problem Orientated Visit (CPT codes 99205-99215) includes discussion and documentation of a presenting problem(s) and any related symptoms or complaints. Conditions may be acute or chronic in nature. The visit requires a medically appropriate history and/or examination and medical decision-making (MDM). Elements of MDM include the number and complexity of problems addressed, the amount and/or complexity of data to review and analyze, and the risk of complications, morbidity, and mortality related to patient management. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

The Health Plan may reimburse for a preventive and problem-orientated visit for the same service date when documentation supports evaluating and managing a separately identifiable problem addressed during the same encounter as the preventive service. The new or preexisting problem or abnormal finding must be significant enough to require additional work and key components of a problem-oriented E/M service outside of the components and work evolved in a preventive medicine E/M service as work efforts may overlap and would be considered double billing when both services are reported with documented support. Documentation must support the additional work, and modifier -25 must be applied to the E/M service. An additional E/M code should **not** be reported with the preventive service if the addressed problem/abnormality is insignificant or trivial and does not require additional work, including the performance of the key components of a problem-oriented E/M service. Discussion of a chronic condition at the time of a preventive visit does not automatically constitute a significant, separately identifiable problem or abnormal finding. Management of chronic conditions where there is no action other than script renewal and possibly surveillance labs are considered part of the routine care provided within the preventive exam review.

Examples:

The patient presents for their annual preventive E/M and mentions they have been experiencing throat pain for several days and mentioned this during the preventive visit. The provider performs additional workups, including a rapid strep test, confirms results, and documents a care plan for the treatment of symptoms (e.g., prescription). Significant additional workup was performed outside the routine preventive exam components and documented. In this instance, the billing of a problem-orientated visit and the preventive well visit *would* be supported.

The patient presents for their annual preventive E/M. The patient has several chronic conditions, including hypertension. The patient's blood pressure reading was noted as high during the encounter. When the practitioner asked the patient how they were feeling, they mentioned a few recent headaches resolved with over-the-counter medication. The provider noted blood pressure results and headaches in the record and documented medication refills. No further action was taken. Therefore, in this instance, the billing of a problem-orientated and preventive well visit *would not* be supported.

Prolonged E/M Services.

The Health Plan reimburses for prolonged services when appropriately billed and supported in documentation in accordance with CMS guidelines for reporting prolonged service time-based units.

1. CPT® 99417 is reportable only with level 5 visits (CPT® codes 99205 & 99215).

2. Documented time must exceed the maximum time for the level 5 office/outpatient E/M visit by at least 15 minutes on the date of service. For example, CPT® 99215 is inclusive of time up to 54

minutes. An initial unit for prolonged services may not be reported until the documented time meets or exceeds 69 minutes.

3. Time alone must be the basis for coding when reporting a prolonged service, and a qualifying statement of time must be included.

4. CPT® 99417 may not be reported for any time less than 15 minutes.

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 healthcare professional 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 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 explicitly for new patients only (CPTs 92002, 92004, 99201-99205, 99321-99323 and 99341-99345). These codes are listed as new patient codes and are automatically excluded from the global surgery package edit. They are reimbursed separately from the surgical procedure, and no modifier is required if the visit meets significant and separately identifiable guidelines.

Split Shared Services

When a physician and Qualified Health Partner (QHP) perform an E/M, the time spent by each is summed for the total time. UM Health Plan aligns with CMS split shared services rules. Split shared does not apply to the office setting. “Incident to” rules apply to the office setting.

Time-Based Code Selection

For those E/M services that allow code selection based on time, the medical record must include a clear time qualification statement with detailed information to support the amount of time reported. The statement should be unique to the patient and not a copy-and-paste statement with general terms. An adequate time qualification statement would include a description or statement of the activities performed on the date of the encounter. Total time documented alone without a qualifying statement does not meet UM Health Plan’s requirements to support time-based billing.

Qualifying time may include activities such as preparing to see the patient (reviewing tests); counseling or educating a patient, family, or caregiver; reporting test results to the patient by phone; ordering medications, tests, or procedures; reviewing separately obtained history; referral coordination for the patient (when not separately reportable). Activities that do not count toward total time include time spent on a calendar day other than the day of the patient encounter, services that are separately reportable under other CPT codes, and clinical staff time. If an unusual amount of time was spent on a task, details regarding why should be included in the medical record. Instead of using a standard template where only the documented minutes change (i.e., XX minutes, for counseling and educating the patient), a unique patient specific statement should be documented in the record. For example, a patient with chronic unstable diabetes and documented non-compliance may require additional counseling time. An appropriate qualifying statement may say:

60 minutes spent counseling and educating the patient with exacerbation of condition due to lack of medication compliance on importance of medication compliance, risks associated with non-compliance, medication side effects, when to contact office or seek medical treatment at the ER. Answered patient’s concerns about what to do when there is a missed dose.

*Time spent on non-medical discussion cannot be counted.

4.0 Documentation Requirements:

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

Some key documentation principles and details to include in medical record 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 copying and pasting or auto filling templates.
- Avoid Check Boxes that don't provide full and accurate details.
- Documentation of E/M encounters 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 are routinely audited. An audit is commonly initiated when the data indicates an outlier, such as a significant deviation from the median billing of their peers. The audit process includes a review of medical records 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 the 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:

Acute, Complicated Injury: An injury that requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Acute, Uncomplicated Illness or Injury: A recent or new short-term problem with a low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolved consistently with a definite and prescribed course is an acute, uncomplicated illness.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. Symptoms presenting outside of the normal course of an illness or injury.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.

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

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed.

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.

Chronic illness, with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control the progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care.

Chronic illness, with severe exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control the progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care.

Clinical Staff: An individual who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service but who does not individually report that professional service. Examples: Medical Assistants, Licensed Practical Nurses, Registered Nurses.

Discussion: Requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision-making of the encounter. It may be asynchronous (i.e., does not need to be in person), but it must be initiated and completed within a short time period (e.g., within a day or two).

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.

External: Records, communications, and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

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

Independent Historian(s) An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent

historian requirement is met. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent Interpretation: The interpretation of a test for which there is a CPT® code, and an interpretation or report is customary. This does not apply when the physician or other qualified healthcare professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Medical Decision Making (MDM): MDM reflects the nature of the patient's presenting problem and the 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 the 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 the 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 healthcare provider has determined that a particular healthcare service or supply is medically appropriate, it does not mean that the procedure or treatment is a Covered Health Service under the Policy.

Minimal Problem A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

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: a review of the patient's family medical history, including diseases that 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: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

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: Service performed beyond the threshold time for the evaluation and management service the physician or qualified health provider provided during the encounter. The threshold is calculated in accordance with CMS guidelines for reporting time-based services.

Qualified Health Provider (QHP): An individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. Examples: Nurse Practitioners, Physician Assistants, Certified Nurse Specialist

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 that the patient may be experiencing.

Risk: Relates to the probability of occurrence. As it relates to E/M coding, a 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 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.

Stable, Chronic Illness: A problem with an expected duration of at least one year or until the patient's death.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis representing a condition likely to result in a high risk of morbidity without treatment.

7.0 References, Citations, Resources & Associated Documents:

1. CMS Transmittal 1764 and 10505
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. Current Procedural Terminology book, available from the American Medical Association.
4. Medicare Claims Processing Manual (Pub. 100-04).
5. American Medical Association https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.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.
1/23	Annual review
10/23	Annual review
10/24	Annual review