Evaluation and Management (E&M) Program Claim and Code Review

Overview

The Evaluation and Management (E&M) Program is part of the Claim and Code Review Program. We contract with a vendor to review coding for E&M services. For select providers, our vendor will evaluate the appropriateness of levels 4 and 5 E&M codes to assess if the level of service billed matches the intensity of the service and the severity of the illness. The edits are not clinical. They are based on external coding guidelines. Our vendor uses certified coders who review the claim billed and the member and provider claim history to make the edit decision.

Purpose

The program evaluates the appropriateness of levels 4 and 5 E&M codes to assess if the level of service billed correlates to the intensity of the service and the severity of the illness.

Application

E&M services may be billed with different levels of service depending on:

- History
- Physical examination
- Medical decision making
- Counseling
- Coordination of care
- The nature of the problem
- Time

We review level 4 and 5 new and established patients E&M codes for office, outpatient, consultation and ophthalmological services. They are reviewed in the context of these guidelines.

The applicable places-of-service include:

- In office
- Off campus - outpatient hospital
- Urgent care facility
- Inpatient hospital
- On campus - outpatient hospital
- Emergency room – hospital

Process

We follow national guidelines for coding and documenting E&M services. Both CMS and the American Medical Association have requirements for new and established patient office visits and consultations. These guidelines include:

- The medical record should clearly reflect the chief complaint.
- Review of systems, and past, family, and/or social history can be subject to updates.
- Generally decision making with respect to a diagnosed problem is easier than for an identified, undiagnosed problem.
- Problems that are improving or resolving are usually less complex than those that are worsening or failing to change as expected.
- The number and type of diagnostic tests used may indicate the number of possible diagnoses.
- The nature of the medical event may affect the assessment of the level of risk.
- Office and other outpatient services (99202-99215) include a medically appropriate history and physical examination, when performed.
    - Use best clinical judgement
    - Nature and extent of history and exam will not impact the level of service
- Appropriate level of service is based on one of the following:
    - Medical decision making
    - Number and complexity of problems addressed at the encounter
    - Amount and/or complexity of data to be reviewed and analyzed
    - Risk of complications and/or morbidity or mortality of patient management decisions made during the visit
    - Total time (counseling and coordination of care). Defined as total time spent on a patient's care on the date of encounter. Includes both face to face service and non-face to face services
    - Only distinct time is summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, count only the time of one individual)

It is not medically necessary or appropriate to bill a higher level of E&M service when a lower level is reasonable. The volume of documentation should not influence the level of service at which your office bills. The documentation in the medical record should support the CPT and ICD codes on the claim form.

More information on CMS and AMA guidelines

CMS Final Rule

AMA website

CMS-E/M Fact Sheet

AAPC

What to do if you disagree with an edit

If you don't agree with an edit, you can follow the process for appeal.

You should include a written request with medical records and notes through the following:

- Address on the Explanation of Benefits
- Using the "Contact us" function through our provider portal on Availity

After reconsideration, the original claim edit may stand. If so, you'll get a notice from us of the decision. It will also explain any further appeal rights.

Some contracts have special dispute provisions. If yours does not, follow the standard timeframes for a claim reconsideration or appeal.

Go to Aetna.com to learn more about our provider claim dispute processes.

For more help and guidance, call the provider service center at **1-888-632-3862 (TTY: 711).**

Methodology

The methodology used depends on the market. For New York, our vendor uses certified coders. They review claims as well as the member and provider claim history, to make the edit decision.