Kansas City

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Evaluation and Management Services

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Description

This policy addresses Blue KC coding and coverage for illness-related and preventive evaluation and management services (E/M). E/M services refer to visits and consultations furnished by physicians or other qualified practitioners.

The E/M section of the CPT manual is divided into broad categories such as office visits, hospital visits and consultations. Each section has basic guides or requirements for selection, such as new versus established patient, or office-versus hospital-based services.

The E/M guidelines define the requirements for individual E/M codes based on the extent of the documentation of the three key components. In general, higher paying E/M codes (like consultations or initial office visits) require more extensive documentation than lower paying codes (such as office visits with established patients or hospital progress notes). In order to understand E/M coding, it is first necessary to understand each of the individual key components.

Policy

General Principles of E/M documentation

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The E/M guidelines define the requirements for individual E/M codes based on the extent of the documentation of the three key components;

- History of Present Illness
- Exam

- Medical Decision Making (MDM)

The MDM component of evaluation and management (E/M) services is perhaps the most crucial element in determining the correct level of service and must be one of the components used for determining the E&M level billed.

Billing Blue KC for an E/M service requires the selection of a Current Procedural Terminology (CPT) code that best represents:

- Patient type
- Setting of service
- Level of E/M service performed

1995 and 1997 E/M Guidelines

What are the differences between the 1995 and 1997 Medicare E/M guidelines when it pertains to the different exam levels?

The 1995 Guidelines define the different exam levels as follows:

- Problem Focused -a limited examination of the affected body area or organ system.
- Expanded Problem Focused -a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- Detailed -an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive -a general multi-system examination or complete examination of a single organ system.

The 1997 Guidelines contain the following definitions:

- Problem Focused Examination -should include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s).
- Expanded Problem Focused Examination -should include performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
- Detailed Examination -should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
- Comprehensive Examination -should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.

Medical Decision Making

The levels of E/M services recognize four types of medical decision making (straight-forward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed;
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Medical decision making is one of the required components in selecting the correct level of service to bill for payment, in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. It is important to note that even if all requirements of a code are documented, if medical necessity is not established, the service may be denied. The volume of documentation should not be the primary influence.

Selecting a Code

When billing for a patient's visit, select codes that best represent the services furnished during the visit. A billing specialist or alternate source may review the provider's documented services before submitting the claim to a payer. These reviewers may help select codes that best reflect the provider's furnished services. However, the provider must ensure that the submitted claim accurately reflects the services provided.

The provider must ensure that medical record documentation supports the level of service reported to a payer. You should not use the volume of documentation to determine which specific level of service to bill.

Services must meet specific medical necessity requirements in the statute, regulations, and manuals and specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations (if any exist for the service reported on the claim). For every service billed, you must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

When may it be appropriate to bill an office visit on the same day as a procedure?

If the patient comes in only for the procedure only bill for the procedure.
If the patient comes in knowing they are going to have the procedure done, but they also have a new complaint, then the practitioner may code for the E/M appended with the -25 modifier and the procedure.

If the patient comes in with a new complaint, and during that time the practitioner makes the decision that a particular procedure needs to be done at that visit, then the practitioner may code for the procedure and the E/M appended with the -25 modifier.

Office or Other Outpatient and Initial Inpatient Consultations

CMS does not allow submission of inpatient and outpatient consultation codes for Medicare claims. This coding and submission will be followed only for our Medicare business. There is no change for all other lines of business. Blue KC accepts all valid HIPAA medical codes. The consultation codes 99241-99245 and 99251-99255 are still valid CPT codes and as such will be accepted. We expect that the documentation will support any code submitted.

Consultation codes 99241-99255 include a physician's or qualified healthcare practitioner's services requested by another physician or other appropriate source, for further evaluation or management of the patient. They are designated according to place of service and apply to new or established patients.

The consultant must document the consult request and the reason for the consult in the patient record and must also appear in the requesting practitioner's plan of care.

The consult request is typically in writing but it may be verbal so long as both the requestor and the consultant document the conversation in the patient medical record. The consultant must provide a written report to the requesting practitioner. A reference to "cc" in the medical record is not sufficient to justify a consultation.

A consultation may include the diagnostic tests needed to provide an opinion or advice. If the physician or qualified healthcare practitioner consultant introduces further therapeutic services, documentation must show that the consultant recommended a course of action at the request of the attending physician or qualified healthcare practitioner. Any subsequent services and continuing care rendered by the consultant cease to be a consultation and become established patient care services.

Initial or subsequent services rendered by a consultant may make an initial consultation invalid if records show that patient care was immediately assumed as in a referral.

A referral is the transfer of total or specific care of a patient from one physician or qualified healthcare practitioner to another and does not constitute a consultation. Initial evaluation and subsequent service for a referral are designated as level-of-service office visits.

Second or confirmatory consults are coded as the appropriate E/M for the setting and type of service.

New and Established Patients

A new patient is one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years.

An established patient is one who has received services from the provider or another provider of the same specialty who belongs to the same group practice, within the past three years.

Multiple E/M's same Day

When multiple E/M services are reported on the same date of service, only the most clinically intense E/M service will be recommended for reimbursement.

This auditing logic is consistent with CMS guidelines from the Medicare Claims Processing Manual, Chapter 12, section 30.6.5 that states,

"If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level."

Only one E/M will be allowed per day per provider or provider group.
Blue KC requires reasonable documentation that services are consistent with the health plan coverage provided, that services are medically necessary, and appropriate diagnostic and/or therapeutic services are provided and/or the services furnished have been accurately reported. Documentation does not need to be submitted with every claim; however, it must be readily available on request or submitted, as appropriate, with an appeal or replacement claim.

Documentation Support

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For E/M services, the nature and amount of physician or qualified health care practitioner work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

- The medical record should be complete and legible. Vitals, forms, and anything pertaining to the visit needs to be complete and contained in the record.
- The documentation of each patient encounter should include:
    - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
    - Assessment, clinical impression or diagnosis
    - Plan for care
    - Date and legible identity of the observer. On review, documentation not signed by the physician/practitioner performing the service will subject the entire visit to denial.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The CPT and ICD codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record. Include ALL diagnoses addressed during the encounter. Diagnoses MUST be coded to the highest degree of specificity for accurate risk adjusted quality review.

Additional reminders:

- Use of the term IBID (same as above) and/or the use of quotation marks to replace or repeat previously documented information is not acceptable. All information must be in date sequence order.
- Uses of question marks (?) or underline (_) are not considered to be part of a complete medical record. Dictation transcription **should be** reviewed by the medical practitioner and updated prior to sign-off to ensure complete medical records are maintained.
- Each page in the medical record must contain the patient’s name and/or identification number.
- All encounters/entries must be dated.

- Services not clearly documented are not covered by Blue KC and will be denied as participating provider liability. Failing to submit requested medical records may result in claims being denied or payment being recouped from a provider. Patients are not financially liable for services that are denied for inadequate documentation.

Time Documentation

The time spent face-to-face with either the patient or family should be noted where counseling and/or coordination of care dominates more than 50 percent of the face-to-face physician time.

You must appropriately and sufficiently document in the medical record that you (the physician or qualified NPP) personally furnished direct face-to-face time with the patient or with a family member. Be sure to include the start and end times of the visit.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

Document Submission

Documentation must identify and describe the procedures performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

The following applies to all claim submissions:
All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue KC Medical Policy criteria, policies found under Provider Payment Policy, Provider Office Guide and all other provisions of the Provider Service Agreement (Agreement). In the event that any new codes are developed during the course of the Provider's Agreement, such new codes will be paid according to the standard or applicable Blue KC fee schedule until such time as a new agreement is reached and supersedes the provider's current agreement. Eligible services will be subject to the subscriber benefits, Blue KC fee schedule amount, and any coding edits.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service

Policy History

DATE	DESCRIPTION
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