Evaluation and Management (E/M) Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

This policy is intended to address Evaluation and Management (E/M) services.

The E/M coding section of the CPT® book is divided into broad categories with further sub-categories which describe various E/M service classifications.

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 reimbursement policy explains when 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 physicians or other health care professionals should best represent the services provided based on the American Medical Association (AMA) and CMS documentation guidelines.

Reimbursement Guidelines

UnitedHealthcare uses an Optum proprietary scoring tool based on the instructions in the 1995 and 1997 CMS documentation guidelines. Medical records are requested when the data shows a physician or other health care professional has a billing pattern that deviates significantly from their peers, or claim attributes indicate possible billing errors. (Note: The reimbursement guidelines for CPT code ranges 99202 – 99205 and 99212 - 99215 have been updated effective January 1, 2021. Click here to review changes.)

Refer to the resource section below for guidance on documenting and reporting E/M services accurately.

The medical record review process takes into consideration CMS documentation guidelines. Based on the record review points are assigned in accordance with the documented medical record. For example, Medical Decision Making (MDM) is one component of the scoring tool as follows:

A. Number of Diagnoses and Management Options	Points Assigned
Self-Limiting or minor Problems (stable, improved or worsening)	1
Established Problem – stable improved	1
Established Problem – Worsening	2
New Problem – No Additional Work-up Planned.	3
New Problem – Additional Work-up Planned	4

Additional Work-up Planned is an element of review which includes a number of diagnoses and management options. The Additional Work-up Planned element contributes to indicating the complexity of a patient based on the clinician's utilization of diagnostic tests.

The Additional Work-Up Planned is a key element for a highly complex E/M service and constitutes any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making. An example of Additional Work-Up Planned is when the provider of service contacts the patient's physician or other specialist with recommendations for additional follow-up care and the discussion is documented in the medical records. A simple instruction to the patient to contact their primary physician does not constitute Additional Work-up Planned.

The examples below are based on a record review assessment and further illustrate the medical decision making component scoring above.

Office E/M documentation:

(1) **Established Problem- Worsening:** An established patient sees his/her gastroenterologist due to worsening of his/her Crohn's disease. The physician provides an E/M service and adjusts the patient's medication. Two (2) points would be assigned for Established Problem- Worsening score.

(2) **New Problem-Additional Work-up planned:** The patient presented to his/her new family practitioner with symptoms requiring additional tests and/or a referral to a specialist. In addition, the family practitioner contacts the specialist directly to discuss the patient's case. Four (4) points would be assigned for New Problem-Additional Work-up Planned score.

Emergency Room/Department E/M documentation:

(1) **New Problem- No Additional Work-up Planned:** A patient presents with a low-grade fever and pharyngitis. An examination is provided and the patient is sent home with a prescription and instructed to follow-up with their primary care physician as needed. Three (3) points would be assigned for New Problem- No Additional Work-up Planned score.

(2) **New Problem – Additional Work-up Planned:** A patient presents with abdominal pain and hematuria. The ER/ED physician (or staff) schedules an outpatient MRI and/or communicates directly with the patient's primary physician or other specialist after discharge from the ER/ED and the discussion has been documented in the medical record. Four (4) points for Additional Work-up Planned would be scored. Credit is not given for Additional Work-up Planned if the clinical testing/consultation occurred during the ER/ED Encounter or in the instance when the patient is instructed to contact their primary physician. This application is consistent with a more complex E/M code level.

Office and Outpatient Evaluation and Management Coding Guidelines Effective January 1, 2021

In alignment with AMA and CMS guidelines, the CPT code section for Office and Outpatient E/M Visits (99202-99205; 99211-99215) include:

- Retaining 5 different code levels for established patient office and outpatient visits
- Reducing to 4 code levels for new patient office and outpatient visits
- Revising the Time element to include the total time spent providing medical care to the patient on the date of the encounter and MDM for all E/M codes
- Allowing clinicians to choose the appropriate E/M level of care based on either MDM or Time.

Time:

Time alone may be utilized to select the appropriate level of care for CPT codes: 99202-99205; 99212-99215.

E/M Documentation Requirements:

Time documentation criteria for time spent face-to-face or non-face-to-face may include, but 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 evaluation and management service

Medical Decision Making Criteria include:

- Number and complexity of problem(s) addressed
- Amount and/or complexity of data reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Click here to go to the beginning of Reimbursement Guidelines

New Patient or Established Patient Status for Emergency Department Visits:
Time is not a descriptive component for emergency department E/M levels of service. Providers must use CPT codes 99281-99285 for emergency department visits (Place of Service 23) for both established patients and new patients for the emergency department visit. (Note: Providers or other health care professionals who are requested to serve as a consult should utilize the appropriate E/M code administered.)

Providers may experience adjustments to, or denials of the office visit or other outpatient E/M code or emergency department 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.

Evaluation and Management Procedure Code List

99202	99203	99204	99205	99211	99212	99213	99214	99215	99217
99218	99219	99220	99221	99222	99223	99224	99225	99226	99231
99232	99233	99234	99235	99236	99238	99239	99241	99242	99243
99244	99245	99251	99252	99253	99254	99255	99281	99282	99283
99284	99285	99288	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99318	99324	99325	99326	99327	99328
99334	99335	99336	99337	99339	99340	99341	99342	99343	99344
99345	99347	99348	99349	99350					

Definitions	
Additional Work-up Planned	Any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making
Encounter	Interaction between a covered member and a health care provider for which evaluation and management service or other service(s) are rendered and results in a claim submission

Questions and Answers	
1	**Q:** When a separate written report for diagnostic services (i.e. 93000, 93005, 93010) is prepared by the same provider or provider group performing the E/M service, should this be counted in determining the level of care? **A:** No. Per AMA guidelines: When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making or the reported time calculation when selecting a level of office or other outpatient E/M service.
2	**Q:** Will UnitedHealthcare require medical records for all reported E/M services? **A:** No. UnitedHealthcare may request medical records when the data indicates a physician or other health care professional has a billing pattern that deviates significantly from their peers, or claim attributes indicate possible billing errors.
3	**Q:** How does the policy apply to Electronic Health Record use? **A:** While there is no prohibition on the use of proprietary templates, documentation from either an electronic health record (EHR) or hard-copy that appears to be cloned (selected information from one source and replicated

	in another location by copy-paste methods) from another record, including but not limited to history of present illness (HPC), exam, and MDM, would not be acceptable documentation to support the claim as billed. The documentation guidelines apply to any medical record produced.

Resources

American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services

Medicare Learning Network Bulletin – Evaluation and Management Services – ICN006764 – Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services including, but not limited to 1995/1997 guidelines

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

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

- 1995 Guidelines: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf
- 1997 Guidelines: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf

Novitas Solutions – Medicare Part B: "Evaluation & Management Services: Medical Decision Making: https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005056

History

6/7/2021	Policy Version Change Attachments Section: Removed attachment(s) and converted to table(s)
1/1/2021	Policy Verbiage Change Sections: Overview, Reimbursement Guidelines, Questions and Answers, Attachments
5/1/2020	Annual Policy Version Change (No New Version)
4/1/2019	Annual Policy Version Change (No New Version)
10/1/2018	Policy Version Change: Policy Clarification: Reimbursement Guidelines Section
9/1/2016	Policy Publication
4/21/2016	Policy Approved by the Payment Policy Oversight Committee

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