CENTENE Corporation

Payment Policy: Leveling of Care: Evaluation and Management Overcoding

Reference Number: CC.PP.066
Last Review Date: 02/2023

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

Physician medical records should chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history. Documentation should support the medical necessity and appropriateness of the diagnosis and/or therapeutic service provided. General principles of E&M documentation established by CMS dictate that providers report diagnosis and treatment codes on the claim form that are consistent with the documentation in the medical record.

There are three **key** components providers must consider when selecting the appropriate level of E&M services provided, history, examination and medical decision making. Providers should consider the extent of the history obtained from the patient, the extent of the examination performed, and the complexity of medical decision-making. When selecting the appropriate level of E&M service, all of the key components must **meet or exceed** the stated requirements to qualify for a particular level of E&M service (i.e., office, new patient, hospital observation services; inpatient hospital care; office consultations etc.).

The purpose of this policy is to ensure that the level of E&M service reported by the provider reflects the services performed. When a provider submits an E&M service that exceeds the maximum level of E&M service based on the diagnosis and other claim documentation elements, the E&M code is reduced to reflect the maximum level of E&M service.

Application

- Physicians and other qualified health care professionals who provide face-to-face services who report evaluation and management services reported by a specific CPT® code(s).
- This policy **does not apply** to professional claims billed in the emergency room setting 99281-99285.
- New office visits, established office visits, new ophthalmology visits, established ophthalmology visits, consult office visits

Reimbursement

The health plan will provide an automated pre-payment (after services are rendered, but prior to claims payment) ***claims*** review process for determining and leveling the correct level of evaluation and management service.

The coding algorithm will evaluate each diagnosis code billed in the claim header, along with historical claims and other claims information (including additional testing/procedures) and determine if the level of E&M service billed is appropriate for the services rendered.

When multiple diagnosis codes are billed, the algorithm will evaluate each code and other claims information and assign a maximum level of service to each diagnosis. As an example, if there are three diagnosis codes billed in the claim header, two of which are assigned a maximum level of service of three (99213) and one (1), which has an assigned maximum level of service of four (99214), then a level four E&M code is allowed.

The minimum level of service is level three (i.e., 99213) for E&M services with five levels and a level two (99232) for E&M services with three levels.

Each E&M category (i.e., new visits, established visits, new ophthalmology visits, established ophthalmology visits and office consultations) has its own assigned values.

E&M services will be not be denied as a result of this policy, but E&M services will be reviewed and may be reduced based on the level of service performed.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.
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CPT/HCPCS Code	Descriptor
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time code for selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time code for selection, 60-74 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time code for selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When

	using time code for selection, 40-54 minutes of total time is spent on the date of the encounter.
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	NA

Definitions:

Evaluation and Management Services

A medical coding process to support medical billing. Health care providers use E&M codes to be reimbursed by Medicare, Medicaid and commercial insurers. These codes describe patient encounters with physicians or other qualified health care professionals and recognize seven components of the patient/physician encounter 1) history; 2) examination; 3) medical decision-making; 4) counseling; 5) coordination of care; 6) nature of presenting problem; and 7) time. E&M standards and guidelines were established by Congress in 1995 and revised in 1997. E&M codes are based on the Current Procedural Technology (CPT®) codes established by the American Medical Association (AMA®).

Overcoding

Billing procedure codes at higher level that what is warranted by the clinical documentation.

References

1. *Current Procedural Terminology (CPT*®), 2023
2. *Centers for Medicare and Medicaid Services,* CMS Manual System and other CMS publications and services.

Revision History	
01/23/2020	Initial Policy Draft
02/06/2020	Final Medical Affairs and Payment Integrity Review, Policy Approved and Watermarks Removed
02/6/2021	Annual Review, updated codes (in accordance w 2021 descriptions) review date and copyright dates
02/6/2022	Conducted annual review, removed product type, confirmed codes, updated review date and copyright dates
02/28/2023	Conducted annual review, confirmed codes and updated descriptions, updated review date and copyright dates

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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