Clover

Clover Health Evaluation and Management Reimbursement Policy

Policy # RP-037

Policy Title	Evaluation and Management Reimbursement Policy
Policy Department	Payment Strategy and Operations
Effective Date	4/1/2022
Revision Date(s)	
Next Review Date	

Disclaimer:

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

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 code sets to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code you may bill within the appropriate category. To bill any code, the services furnished must meet the definition of the code. You must ensure that the codes selected reflect the services furnished.

The three key components when selecting the appropriate level of E/M services provided are history, examination, and medical decision making. Visits that consist predominantly of counseling and/or coordination of care are an exception to this rule. For these visits, time is the key or controlling factor to qualify for a particular level of E/M services.

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

Definitions:

Evaluation and Management (E/M) Services - Cognitive services in which a physician or other qualified healthcare professional diagnoses and treats illness or injury.

Medical Decision Making (MDM) - Decision making refers to the complexity of establishing a diagnosis and/or selecting a management option.

Policy:

This policy is intended to address Evaluation and Management (E/M) services. Physicians should use CPT code (level 1 of HCPCS) to code physician services, including evaluation and management services. Clover Health will pay for E/M services for specific nonphysician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Clover Health benefit permits them to bill these services.

For purposes of the medical record audits of E/M coding levels, the Plan expects the medical records will reflect the MDM component and is aligned with the complexity of the patient history and examination. The Plan considers MDM as one of the key parameters in determining whether up coding has occurred when auditing E/M services. This position is based on the Plan's interpretation of the 1995 and/or 1997 E/M documentation guidelines. found in the Medicare Claims Processing Manual, Chapter 12; section 30.6.1.

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

Medical Decision Making Medical:

Decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering these factors:

- 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.

Number of Diagnoses and/or Management Options:

The number of possible diagnoses and/or the number of management options to consider is based on:

- The number and types of problems addressed during the encounter.
- The complexity of establishing a diagnosis.
- The management decisions made by the physician. In general, decision making for a diagnosed problem is easier than decision making for an identified but undiagnosed problem. The number and type of diagnosed tests performed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected. Another indicator of the complexity of diagnostic or management problems is the need to seek advice from other health care professionals.

Amount and/or Complexity of Data to Be Reviewed:

The amount and/or complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

- A decision to obtain and review old medical records and/or obtain history from sources other than the patient (increases the amount and complexity of data to be reviewed).
- Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test (indicates the complexity of data to be reviewed).
- The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation (indicates the complexity of data to be reviewed).

Clover Health may require reasonable documentation to ensure that a service is consistent with the patient's insurance coverage and to validate:

- The site of service.
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided.
- That services furnished were accurately reported

Claim Codes (if applicable)	**Office/Outpatient E/M Codes: New Patient** ● 99201 Deleted code (1/1/2021)

	• 99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter. • 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter. • 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 for code 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 for code selection, 60-74 minutes of total time is spent on the date of the encounter **<u>Office/Outpatient E/M Codes: Established Patient</u>** • 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problem(s) are minimal. [No time reference] • 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code

	selection, 10-19 minutes of total time is spent on the date of the encounter. ● 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 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 for code 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 for code selection, 40-54 minutes of total time is spent on the date of the encounter.

References
Medicare Claims Processing Manual Chapter 12
Evaluation & Management MLN