Claims and Payment Policy: E/M Overcoding Policy

Policy Number: CPP-110

Original Effective Date: 10/21/2019
Revised Date(s): 11/13/2019

BACKGROUND

Evaluation and management (E/M) services are visits performed by physicians and non-physician practitioners to assess and manage a patient's health. Both CMS and the OIG have documented that E/M services are among the most likely services to be incorrectly coded, resulting in improper payments to practitioners.

The OIG has also recommended that payers continue to help to educate practitioners on coding and documentation for E/M services, and to develop programs to review E/M services billed for by high-coding practitioners.

POSITION STATEMENT

Overview of WellCare's E/M Program:

- Evaluates and reviews high-level E/M services for high-coding practitioners, which appear to have been incorrectly coded based upon diagnostic information that appears on the claim, and peer comparison.
- Applies the relevant E/M policy and recoding of the claim line to the proper E/M level of service.
- Allows reimbursement at the highest E/M service code level for which the criteria is satisfied based on our risk adjustment process.

Pre Pay Review

Providers should report E/M services in accordance with the American Medical Association's (AMA's) CPT Manual and the Centers for Medicare and Medicaid Services (CMS) guidelines for billing E&M service codes; *"Documentation Guidelines for Evaluation and Management".* The proper reporting of E/M Services enables WellCare Health Plans, Inc. to more precisely apply reimbursement-coding guidelines and ensure that an accurate record of patient care history is maintained.

Determinations as to whether services are reasonable and necessary for an individual patient should be made on the same basis as all other such determinations – with reference to accepted standards of medical practice and the medical circumstances of the individual case.

Post Pay Review

If you do not agree with a payment determination, you have the right to file a grievance by submitting the portion of the medical record that supports additional reimbursement. WellCare will review the submitted medical record(s) to assess the intensity of service and complexity of medical decision-making for the E/M services provided.

Disputes

Providers will have dispute rights on all E&M recode claims for reason codes LT194 and LT195.

Please submit disputes to WellCare Health Plans, ATTN: CCR, P.O. Box 31394 Tampa, FL 33631-3394 and refer to WellCare's Quick Reference Guide (QRG) for additional instructions.

CODING & BILLING

99201-99205	New Office Visits
99211-99215	Established Office Visits
99281-99285	Emergency Department Visits

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

DEFINITIONS

Evaluation and Management Services	Visits performed by physicians and non-physician practitioners to assess and manage a patient's health.

REFERENCES

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
2. Centers for Medicare and Medicaid Services (CMS)
3. Office of Inspector General https://oig.hhs.gov/oei/reports/oei-04-10-00181.pdf

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
10/21/19	• Approved by RGC

Original Effective Date: 10/21/2019 - Revised: 11/13/2019
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