Update to evaluation and management services correct coding - professional

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Effective January 1, 2021, the Centers for Medicare & Medicaid Services (CMS) aligned evaluation and management (E/M) coding with several changes adopted by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel for office/outpatient E/M visits, including providing professional providers with the choice to document office/outpatient E/M visits via medical decision making (MDM) or time. As a result, we have updated the communication titled “Evaluation and management services correct coding - professional” we published in the November 2020 issue of *Provider News* to capture this change, and for your convenience we have included the updated communication below.

Anthem continues to be dedicated to delivering access to quality care for our members, providing higher value to our customers and helping improve the health of our communities. In an ongoing effort to promote accurate claims processing and payment, we are taking additional steps to assess selected claims for evaluation and management (E/M) services submitted by professional providers. Beginning on January 1, 2021, we will be using an analytic solution to facilitate a review of whether coding on these claims is aligned with national industry coding standards.

Providers should report E/M services in accordance with the American Medical Association (AMA) CPT® manual and CMS guidelines for billing E/M service codes: *Documentation Guidelines for Evaluation and Management*. The coded service should reflect and not exceed the level needed to manage the member’s condition(s).

Claims will be selected from providers who are identified as coding at a higher E/M level as compared to their peers with similar risk-adjusted members. Prior to payment, we will review the selected E/M claims to determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E/M code level submitted is higher than the E/M code level supported on the claim. If the E/M code level submitted is higher than the E/M code level supported on the claim, we reserve the right to:

- Deny the claim and request resubmission of the claim with the appropriate E/M level
- Pend the claim and request documentation supporting the E/M level billed
- Adjust reimbursement to reflect the lower E/M level supported by the claim

The maximum level of service for E/M codes will be based on the complexity of the medical decision-making or time and reimbursed at the supported E/M code level and fee schedule rate.

This initiative will not impact every level four (4) or five (5) E/M claim. Providers whose coding patterns improve and are no longer identified as an outlier are eligible to be removed from the program.

Providers who believe their medical record documentation supports reimbursement for the originally submitted level for the E/M service will be able to follow the dispute resolution process (including submission of such documentation with the dispute).

If you have questions on this program, contact your contract manager or Network Relations.

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