BlueCross BlueShield of Texas

CLINICAL PAYMENT AND CODING POLICY

In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC) Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code edit protocols for services/procedures billed.

Evaluation and Management (E/M) Coding – Professional Provider Services

Policy Number: CPCP024

Version 5.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: 10/04/2019

Plan Effective Date: January 25, 2020 (For Blue Cross and Blue Shield of Texas Only)

Description

This Clinical Payment and Coding Policy is intended to provide guidance for professional providers (physicians or other qualified health care professionals) submitting reimbursement for the code(s) that correctly describe the health care services rendered. The information in this policy serves only as a reference resource for the E/M Services described and is not intended to be all inclusive. This policy applies to all professional provider health care services billed on CMS 1500 and UB04 forms. This policy applies to In-network and out of network professional providers.

Claim submissions codes with the correct combination of procedure code(s) are critical to minimizing delays in claim(s) processing. Professional claims submissions should contain the appropriate CPT or HCPCS codes and ICD diagnosis codes.

Reimbursement Information:

All individual patient medical record documentation of services rendered much indicated the presenting symptoms, diagnoses and treatment plan and a written order by the provider. All contents of medical records should be clearly documented including clinical notes, consultation notes, lab reports, pathology reports and radiology reports. **Medical records and itemized bills may be requested from the provider for review to validate the level of care rendered and services billed.** Medical records will be reviewed to determine the extent of history, extent of examination performed, complexity of medical decision making (number of diagnosis or management options, amount and/or complexity of data to be reviewed and risk of complications and/or morbidity or mortality) and services rendered. **This information in conjunction with the level of services billed for the level of care rendered may be reviewed and evaluated to determine if the level of service was appropriately billed.**

Professional Level of Service Guideline

E/M services are broken down into three (3) key components to determine the most appropriate E/M level of care code for services rendered: Extent of History, Extent of Examination Performed and Medical Decision-Making Complexity. The three components have different levels outlined within this policy. For additional information that is not captured below, refer to CMS published documentation guidelines for evaluation and management services.

History is documented with four (4) types, Problem focused, Expanded Problem Focused, Detailed and Comprehensive. These can include Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS) and Past, Family, and/or Social History (PFSH). The plan follows the CMS Documentation Guidelines for E/M services below that outline the progression for each type of history. In addition,

- All items must be met to qualify for a type of history;
- CC is indicated at all levels;
- CC, ROS, and PFSH may be listed as separate elements or they may be included in the description of the HPI.

Type of History	HPI	ROS	PFSH
Problem Focused	Brief	N/A	N/A
Expanded Problem Focused	Brief Problem	Problem Pertinent	N/A
Detailed	Extended	Extended	Pertinent
Comprehensive	Extended	Complete	Complete

Exam is documented with four (4) types, Problem Focused, Expanded Problem Focused, Detailed and Comprehensive. The examination is based on clinical judgement, patient history and the presenting problem(s).

Exam	Problem Focused:	Expanded Problem Focused:	Detailed:	Comprehensive:
	Limited exam of the affected body area or organ system.	Limited exam of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).	Extended exam of the affected body area(s) or organ systems and any other symptomatic or related body area(s) or organ system(s).	General multi-system exam, or complete exam of a single organ system and other symptomatic or related body area(s) or organ system(s).

Medical Decision Making is documented by the complexity of establishing the diagnosis and/or management options that are measured by:

- The number of possible diagnosis and/or number of management options to be considered;
- The amount and/or complexity of medical records, diagnostic tests, notes, reports or other information that must be obtained and reviewed and analyzed;
- The risk of significant complications, morbidity and/or mortality, as well as co-morbidities that are associated with the patient's presenting problems, diagnostic procedures and/or possible management options.

To qualify for a specific type of medical decision-making, you must meet or exceed two (2) out of the three (3) elements.

Type of Medical Decision Making:	Straight Forward	Low Complexity	Moderate Complexity	High Complexity
Presenting Problems:	One self-limited or minor problem.	Two or more self-limited or minor problems.	One or more chronic illnesses with mild exacerbation, progression or side effects of treatment.	One or more chronic illnesses with severe exacerbation, progression or side effects of treatment.
1. Number of Diagnosis or Management Options:	Minimal	Limited	Multiple	Extensive
2. Amount and/or Complexity of Data to be Reviewed:	Minimal or None	Limited	Moderate	Extensive
3. Risk of Significant Complications, Morbidity, and/ or Mortality	Minimal	Low	Moderate	High

The inclusion of a code below does not guarantee reimbursement.

For a current list of E/M codes with details including time parameters, refer to the most current version of the American Medical Association (AMA) CPT or HCPCS codebook. This policy does not apply to all E/M codes listed in the E/M section of the CPT Codebook. CPT codes listed below may be subject for review before payment can be made:

99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285

Critical Care codes **99291** and **99292** are reviewed using the criteria listed in the American Medical Association, CPT Codebook:

- **99291** Critical Care First Hour: First 30-74 minutes of critical care. There is a 30-minute time requirement for billing of critical care. The administration and monitoring of IV vasoactive medications (such as adenosine, dopamine, labetalol, metoprolol, nitroglycerin, norepinephrine, sodium nitroprusside, continuous infusion (drips), etc. is indicative of critical care.
- **99292** Additional 30 minutes: CPT 99291 plus additional 30-minute increments (beyond the first 74 minutes). Medical records must document the total critical care time.

References:

Department of Health and Human Services Centers for Medicare & Medicaid Services, Evaluation and Management Services Guide

Center for Medicare and Medicaid Services: 1997 Documentation Guidelines for Evaluation and Management Services

Policy Update History:

Date	Description
10/04/2019	New Policy