September 16, 2013

E/M Codes: Billing, Documentation, Audits and Claim Payments

Dear Network Prescriber,

The American Medical Association's release of revised CPT® codes for 2013 brought industry-wide changes, including the introduction of Evaluation and Management (E/M) codes for use by behavioral health prescribers. While E/M codes have long been in use by other physicians, it is new for behavioral health. Psychiatrists and nurse practitioners with prescribing authority are continuing to learn how to apply and adequately document those codes for billing. This notice is intended to provide guidance and resources related to documentation requirements for E/M services. In addition, we want to remind you that we have an audit process related to billing and coding.

Documentation and Payment

Included in this communication is an alert related to documentation. It includes some resource links to help you more readily access information about E/M codes and, in particular, materials aimed at supporting documentation of services. Documentation is critical to ensure payment for the services you render. *In the event of an audit, claim submissions with records that do not support an E/M code billed will be denied. You will then have the option of either submitting a corrected claim for the services as supported by the documentation provided for the audit, or submit an appeal with additional supporting documentation.*

Audits

We may request documentation to verify the services billed are recorded in a manner consistent with industry guidelines. In line with HIPAA rules associated with Treatment, Payment and Operations, we may ask for Progress Notes to complete the audit. Progress notes should include, but are not limited to: Medication prescription monitoring (if applicable), functional status, symptoms, session start and stop times modalities and frequency of treatment furnished, clinical testing results (if applicable) and a summary of the following: diagnosis, treatment plan/goals, prognosis and progress to date. Any additional information that is necessary to support the services billed should also be provided at this time.

We will reinitiate audits for compliance with E/M code billing and documentation effective December 1, 2013. As noted, claim submissions lacking appropriate industry-defined documentation, are subject to denial.

We appreciate your participation in the Optum* network. If you have questions about this notice, please contact Network Management at (877) 614-0484.

Sincerely,

Deb Adler
Sr. Vice President, Network Services

Amanda North
Director of Special Investigations

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* United Behavioral Health operating under the brand Optum
U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Health Solutions of California

E/M Codes: Documenting your work

Alert: Industry changes require changes in billing and documentation

Timeline challenges

- October 2012 AMA Announces CPT® Code changes, most significant change for behavioral health in over a decade
- November 2012 CMS provides reimbursement schedule
- January 1, 2013 all providers and payers must implement use of new codes

We recognize that these time parameters have been very challenging for behavioral health providers who continue to learn about and effectively apply E/M codes for both billing and medical record documentation.

3 Key Components of E/M Services reflect levels of intervention

History: Problem focus, Expanded problem focus, Detailed, or Comprehensive
Examination: Problem focus, Expanded problem focus, Detailed, or Comprehensive
Medical Decision-Making: Straightforward, Low, Moderate, or High

Each of these components contains multiple elements, some of which may not apply in every case. Appropriate coding is dependent upon what level of assessment is required to meet individual needs. When greater assessment detail and more complex decision-making are required, higher level codes are applied and documentation requirements increase. New patients always require some level of all 3 components while established patients require that 2 of the 3 components apply at specific levels. The table below highlights the two highest level E/M codes used for established patients in office/outpatient setting.

Patient Type	Location	History	Exam	Decision-Making	CPT Code
Established	Office/OP	Detailed	Detailed	Moderate	99214
Established	Office/OP	Comprehensive	Comprehensive	High	99215

Example: Documentation Requirements for 99214

Detailed History must include:

- Chief Complaint
- Extended HxPI – 4 or more descriptors, or 3 chronic conditions
- Pertinent past, family, social history (1element)
- Extended Review of Systems (2-9 systems)

Detailed Examination must include:

- Refer to Psychiatric section of the CMS 1997 Documentation Guidelines for Evaluation and Management
- Include at least 9 elements identified by a bullet

Medical Decision Making – Moderate Complexity

- Multiple number of diagnoses or management options
- Multiple amount and/or complexity of data to be reviewed
- Moderate risk of complications and/or morbidity or mortality

Resources

- American Psychiatric Association CPT Changes for 2013: http://www.psych.org/cptcodingchanges, all links under E/M
  - E/M Documentation Templates – Word documents, support capturing required data; other samples also available through various online resources
  - E/M Services Guide: Coding by Key Components
- CMS Documentation Guidelines for Evaluation and Management (E/M) Services
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html