March 18, 2020

Provider Memorandum

Coding of Evaluation and Management Services

In an ongoing effort to ensure accurate claims processing and payment, Molina Healthcare of Illinois (Molina) is taking additional steps to verify the accuracy of payments made to professional providers. Beginning on June 1, 2020, as part of our claims process, Molina will be reviewing select claims for evaluation and management (E&M) services to better ensure that payments are aligned with national industry coding standards.

Molina is implementing a program to evaluate and review high level E/M services for high-coding practitioners that appear to have been incorrectly coded, based upon diagnostic information that appears on the claim and peer comparison.

Evaluation and management services are visits performed by physicians and non-physician practitioners to assess and manage a patient's health. Both Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (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.

The following are example remittance messages which may be included but not limited to future E&M claims processed:

- Line (X) Service Code '99204, 99205, 99215, 99214' visit level lowered to "99203, 99204. 99213, 99214"
- This claim line was processed using a code that more accurately represents the treatment received.
- The information submitted on the claim does not support the code originally billed. The provider has been reimbursed using the level (insert level) evaluation and management code which more appropriately supports the information submitted on the claim
- Payer deems the information submitted does not support this level of service.

If you do not agree with a payment determination, you have the right to file a dispute by submitting the portion of the medical record that supports additional reimbursement. Molina Healthcare 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. Steps on how to submit a dispute can be found at: molinahealthcare.com/providers/il/PDF/Medicaid/Claim-Appeal-and-Dispute-Memo-Reminder-FNL-v1-7119.pdf.

Medical Necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of

evaluation and management service when a lower level or service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. CMS Regulations and Guidance cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf

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 level of service for E&M service codes is based primarily on the member's medical history, examination and medical decision-making. Counseling, coordination of care, the nature of the presenting problem, and face-to-face time are considered contributing factors.

Questions

Providers who have questions, concerns or would like additional training, including how to use the Molina Provider Portal, may contact their provider network managers or email the Provider Network Management Department, MHILProviderNetworkManagement@MolinaHealthcare.com.

For help identifying your provider network manager, visit Molina's Service Area page at MolinaHealthcare.com.

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