KAISER PERMANENTE®

PAYMENT POLICY

HIGH LEVEL EVALUATION AND MANAGEMENT SERVICES WITH A DIAGNOSIS OF "NO ABNORMAL FINDINGS"

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington

☒ Kaiser Permanente Health Plan of Washington Options, Inc.

☒ Commercial

☒ Medicare

☐ Medicaid

Policy

Original Effective Date: 01/01/2021

When benefits allow, Kaiser Permanente will reimburse professional claims billed with high level Evaluation and Management codes (99204, 99205, 99214, 99215) when the presenting problem(s) support the level of the visit. AMA and CMS documentation guidelines should be utilized. Since the higher-level E/M codes require decision making of moderate to high complexity, if the only diagnosis on the claim is "Encounter for xxx with no abnormal findings", the likelihood for moderate to high complexity decision making is low. Therefore, higher level E/M's (99204, 99214, 99205, 99215) will be denied coverage if the only diagnosis on the claim is an encounter with no abnormal findings.

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

Policy Definitions

CPT Evaluation and Management guidelines states: all of the key components, ie history, examination, and medical decision making or time, must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient.

Medical Decision Making refers to the complexity of establishing a diagnosis and/or selecting a management opinion as measured by:

- The number of possible diagnosis and/or the number of management options that must be considered.
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
- The risk of significant complications, morbidity, and /or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, **two of the three elements; number/complexity of problems/data/risk must be met or exceeded.**

Moderate complexity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High complexity: A problem where the risk of morbidity without treatment OR high probability of severe, prolonged functional impairment. “High level E/M Codes should have a moderate or high severity diagnosis code.”

Time: For coding purposes, time for these services (99204, 99205, 99214, 99215) is total time on the date of the encounter. It includes both the face to face and non-face to face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time for the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).

Time activities that count when performed can be:

- Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medical appropriate examination
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests or procedures
- Referring and communication with other health care professionals
- Documenting clinical information in the electronic or other health record
- Independently interpreting results
- Care coordination

Prerequisite(s)

Not applicable

References

Current Procedural Terminology (CPT) 2021 https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

1995 Guidelines: 1995 Documentation Guidelines For Evaluation and Management Services (PDF)

1997 Guidelines: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Frequently Asked Questions

Q1: Why is Kaiser Permanente implementing a high-level Evaluation and Management code review?

A1: To ensure appropriate and fair level of reimbursement for Office and Outpatient Evaluation and Management services.

Q2: What criteria is considered in the evaluation?

A2: The presenting problems defined by the ICD-10 diagnosis codes submitted when the *only* diagnosis present on the claim line is “Encounter for xxx without abnormal findings”.

Q3 What should providers do to ensure fair reimbursement on submitted high level Office and Outpatient services.

A3: Claims for High Level Evaluation and Management services rendered should follow CPT and CMS requirements to qualify for a particular level of E/M service for office and outpatient. If a diagnosis was omitted on the claim that justifies the higher-level E/M, the claim may be appended and resubmitted for payment consideration.

Q4: Are submitted claims for high level Evaluation and Management codes recoded by the payer.

A4: No. If the level of Evaluation and Management service billed is not supported by the presenting ICD-10 CM codes, the service will be denied.

Revision History

08/29/2022 – Updated formatting

11/03/2020 – New Policy effective 1/1/2021.