E&M Payment Integrity Program Announcement

Molina Healthcare of Utah
7050 S Union Park Center, Ste 200
Midvale, UT 84047

April 16, 2020

Dear Provider:

This decision letter is to notify you in June 2020, Molina Healthcare will be implementing a program to evaluate and review high level Evaluation and management (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.

E/M services are visits performed by physicians and non-physician practitioners to assess and manage a patient's health. Both 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.
- Alert: Payment based on an appropriate level of care

*The below is tailored to the E&M claim selection process, rather than a usual policy edit.

Effective Coding of Evaluation and Management Services
Evaluation and management (E/M) services are visits performed by physicians and non-physician practitioners to assess and manage a patient's health. Molina Healthcare will be instituting a process 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. If you do not agree with a payment determination, you have the right to file an appeal 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.

> 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 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf

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

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.
Thank you for the opportunity to review and respond to this inquiry.

To appeal this decision please follow the standard Appeals process indicated in your Provider Manual.

Sincerely,