Proprietary Evaluation and Management (E&M) Program Claim and Code Review
Program effective July 1st, 2025

Purpose:
The purpose of this policy is to ensure appropriate provider reimbursement in accordance with best practice standards. Aetna Better Health of Kentucky has implemented additional enhancements to our claims editing programs that promote correct coding and billing practices.

Our goal is to ensure consistency and appropriate selection of E&M codes throughout our network and keep medical costs consistent.

Overview:
The Evaluation and Management (E&M) Program is part of the Claim and Code Review Program. We contract with a vendor to review coding for E&M services. For select providers, our vendor will evaluate the appropriateness of E&M codes such as the use of Level 4 versus 5 to assess whether the level of service billed matches the intensity of the service and the severity of the illness.

The edits are not clinical. They are based on external coding guidelines. Our vendor uses certified coders who review the claim billed and the member and provider claim history to make the edit decision.

This program reviews E&M claims for the professional office & outpatient, as well as facility and ED physician claims.

Process:
E&M services may be billed with different levels of service depending on:
- History
- Medical decision making
- Coordination of care
- Time
- Physical examination
- Counseling
- The nature of the problem

We review new and established patients E&M codes for office, outpatient, consultation, and ophthalmological services. They are reviewed in the context of these guidelines.

The applicable places-of-service include:
- Office
- On campus - outpatient hospital
- Urgent care facility
- Skilled Nursing Facility
- Off campus - outpatient hospital
- Inpatient hospital
- Emergency room
- Home

Physician and non-physician practitioners who provide:

- Office and other outpatient services
- Hospital observation
- Inpatient services
- Consultations
- Emergency Department Visits
- Nursing Facility Services
- Domiciliary Services
- Home Services

We follow national guidelines for coding and documenting E&M services. Both CMS and the American Medical Association have requirements for new and established patient office visits and consultations. These guidelines include:

- The medical record should clearly reflect the chief complaint.
- Review of systems, and past, family, and/or social history can be subject to updates.
- Generally, decision making with respect to a diagnosed problem is easier than for an identified, undiagnosed problem.
- Problems that are improving or resolving are usually less complex than those that are worsening or failing to change as expected.
- The number and type of diagnostic tests used may indicate the number of possible diagnoses.
- The nature of the medical event may affect the assessment of the level of risk.
- Office and other outpatient services such as (99202-99215) include a medically appropriate history and physical examination, when performed.
  - Use best clinical judgement
  - Nature and extent of history and exam will not impact the level of service
- Appropriate level of service is based on one of the following:
  - Medical decision making
  - Number and complexity of problems addressed at the encounter
  - Amount and/or complexity of data to be reviewed and analyzed
  - Risk of complications and/or morbidity or mortality of patient management decisions made during the visit
  - Total time (counseling and coordination of care). Defined as total time spent on a patient's care on the date of encounter. Includes both face to face service and non-face to face services
  - Only distinct time is summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, count only the time of one individual)

It is not medically necessary or appropriate to bill a higher level of E&M service when a lower level is reasonable. The volume of documentation should not influence the level of service at which your office bills. The documentation in the medical record should support the CPT and ICD codes on the claim form.

CARC/RARC

CARC	RARC
252 - AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE	M127 - MISSING PATIENT MEDICAL RECORD FOR THIS SERVICE
	N183 - ALERT: THIS IS A PREDETERMINATION ADVISORY MESSAGE, WHEN THIS SERVICE IS SUBMITTED FOR PAYMENT ADDITIONAL DOCUMENTATION AS SPECIFIED IN PLAN DOCUMENTS WILL BE REQUIRED TO PROCESS BENEFITS.
252-AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE	M127-MISSING PATIENT MEDICAL RECORD FOR THIS SERVICE.

Outcome

If the E&M code submitted is higher than the E&M level supported, Aetna Better Health of Kentucky may:

- adjust reimbursement to reflect the lower level of E&M code
- deny claim and provider has the right to appeal by following the dispute resolution process
- recover payment previously made on the claims that exceeds the determined appropriate E&M level.

Next steps:

If you disagree with outcome of the review, you have the right to request an appeal by submitting the portion of the medical record that supports additional reimbursement.

ABHKY 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. Grievance or appeals can be submitted online, by phone, email, or mail/fax. Please www.AetnaBetterHealth.com/Kentucky for additional information.

More information on CMS and AMA guidelines

CMS Final Rule

AMA website