PROVIDER BULLETIN

Date:	April 15, 2019
Purpose:	Provider Bulletin: Evaluation and Management (E&M) Information
Subject:	National guidelines for coding and documenting evaluation and management services
Products:	MMA, FHK, LTSS
From:	Provider Relations – Medicaid

Dear Providers,

Aetna Better Health of Florida (ABHFL) is committed to correct coding and the implementation of programs that result in fair, widely recognized and transparent payment policies. Evaluation and management coding is an area that the Centers for Medicare and Medicaid Services has identified as having significant error rates.

Aetna Better Health of Florida implemented an enhancement to our payment policy editing processes. We are reviewing select claims for evaluation and management services to better ensure payments are aligned with national industry coding standards. To avoid receiving payment policy edits on your E&M services, ABHFL recommends that physicians carefully document and code each service rendered according to national guidelines. Physicians identified for Evaluation and Management (E&M) payment policy editing will receive a letter explaining the process.

It is imperative that you are following national guidelines when you are coding and documenting Evaluation and Management (E&M) services. Both CMS and the American Medical Association have guidelines that provide specific 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 a form which may be updated. The provider must refer to the earlier encounter by date
- A notation of “exam normal” or “exam negative” is insufficient documentation
- Generally, decision making with respect to a diagnosed problem is easier than that for an identified, undiagnosed problem
- Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected
- The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses
- The assessment of risk of the presenting problems is based on the risk related to the disease process anticipated between the present encounter and the next one

Aetna Better Health® of Florida
1340 Concord Terrace
Sunrise, FL 33323

According to the CMS guidelines*, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code." The CPT and ICD codes reported on the health insurance claim form should be supported by the documentation in the medical record.

Make sure your office is carefully documenting and coding services rendered by following CMS and AMA guidelines. More information is available in the CMS *Evaluation and Management Services Guide*.

* CMS Internet Only Manuals, *Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1.* Retrieved July 1, 2015 from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

If you have any questions or urgent concerns, please contact your Network Relations Consultant or a Provider Relations representative for assistance in resolving any issues.

We appreciate your continued service to our members. Please feel free to contact us via e-mail FLMedicaidProviderRelations@aetna.com, fax 1-844-235-1340 or speak to a Provider Relations Representative: (MMA) 1-800-441-5501, (LTC) 1-844-645-7371, or (FHK) 1-844-528 5815.

Sincerely,

Provider Relations

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