UHA
HEALTH INSURANCE

Evaluation and Management Services

I. Policy

University Health Alliance (UHA) will reimburse for office visits and consultations when they are determined to be medically necessary and/or when they meet the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. UHA benefit payments are made for evaluation and management (E/M) visits and office consultations according to the following:

1. New Patient:

    a. A member is a new patient when the patient has not been seen before by the physician, or the patient has not been seen by the physician within the past three years.

    b. For physicians in a group or clinic practice, the patient is considered a new patient when they have not been seen by another physician of the same specialty in the same group or clinic within the past three years.

2. Established Patient:

    a. A member is an established patient when the patient's medical history should be familiar to the physician and the patient has been treated by the physician within three years of the visit.

    b. When a physician is covering for another physician who is in the same practice or clinic, the visit is not considered a new patient visit and payment is based on the eligible charge for an established patient visit.

    c. In addition, a new patient visit should not be billed when a physician changes the location of his or her practice. If the physician has treated the patient within the past three years, the patient is considered an established patient, regardless of the location where the patient is being treated.

3. Consultations:

    a. An office consultation is a service rendered by a physician whose opinion or advice regarding a specific problem or condition is sought by another physician. The physician requesting the consultation generally continues to manage the patient's care following the consultation. The consulting physician may recommend or initiate diagnostic and/or therapeutic services. The consulting physician's report must be forwarded to the requesting physician and the transfer of information must be memorialized. See also UHA policy for Telehealth consultations as additional criteria may apply.

    b. Please note that the following are not considered office consultations:

        i. Predetermined transfer of patient care from one physician to another. If a physician refers a patient to another physician in a different specialty or subspecialty for evaluation and treatment of a specific condition, this service is a referral and should be billed by the referred physician as a new or established patient visit as appropriate.

ii. Services requested by the patient and/or the patient's family and not requested by another physician ("self-referral"). These services should be billed as a new or established patient visit at an appropriate level.

iii. Follow-up consultations. These services should be reported as established patient visits (CPT 99211-99215).

iv. Consultations required by hospital rules and regulations.

v. Anesthesia consultations.

vi. Telephone consultations.

vii. Radiological (except for therapeutic services) or pathological consultations.

viii. Consultation within the same specialty or subspecialty.

B. Except as otherwise defined by UHA, payment for E/M codes requires that services be provided and documented in accordance with the current AMA/CPT guidelines.

C. "Medical necessity" of services is imperative and is recognized by its Hawaii Revised Statute definition and applied through evidence-based criteria including, but not limited to, those provided by Milliman Guidelines and other professional directives and advisories (e.g., ASCO, AHA, APTA, etc.). Medical necessity is the overarching criterion for the payment for all services.

1. Only information that is pertinent to the service the patient received will be considered when verifying level of service being billed.

    a. Higher level billing based on over documentation or inauthentic data will not be reimbursed. Copying and pasting archived or other providers' work product without contemporaneous verification is unacceptable.

2. Care must meet criteria set forth in the UHA Medical Necessity Decision Policy

D. The indications for consultations and diagnostics must be clearly noted to justify reimbursement.

1. Each test or referral must be specifically linked to explicitly documented indications.

2. Blanket, boiler plate, or casual orders (e.g., "usual labs") will not suffice.

E. Independent billing may be accepted for Advanced Practice Provider (APP) services. However, immediate supervision by an onsite physician or shared visit/ incident to oversight may be required for the initial evaluation and/ or diagnostic testing of any medical condition of sufficient complexity that may require expertise beyond APP training or specialty certification.

1. UHA supports team-based health care models and the policies set forth by the American College of Physicians (ACP). It is highly recommended that APP's have a collaborative or supervision agreement with a physician.

2. Each patient should have an ongoing relationship with a physician trained to provide first contact, continuous and comprehensive care. Ongoing care is to be provided in a collaborative approach to care coordination and management with the physician as the primary leader of team-based care model.

3. APP must practice within their usual scope of practice, commensurate to their training, specialty education and/ or certification and experience.

4. UHA may deny payment if an APP is found to practice outside their usual scope of practice or experience or if medical necessity arises.

5. Clinical encounters where the APP is the primary provider and author of clinical documentation should be billed under the APP and not the supervising/collaborating physician.

F. Documentation must be clear, legible, and readily available to UHA. Medical records may be requested to evaluate for medical necessity, quality, and accuracy of coding.

1. Documentation must support the levels of services as defined by current CPT and CMS guidelines.
2. Rationale for labs, tests, procedures, and unusually frequent follow-up must be clear.
3. To maintain an accurate medical record, documentation must be contemporaneous with the service or completed as soon as practicable after the service is provided.
4. Documentation after a week of the date of service would rarely be acceptable (and would require valid reasoning if requested by UHA.) Potential exceptions may include documentation that is accurately supplemented and prompted by hand rendered images or photographs created at the time of service.

G. UHA does not allow separate payment of E/M services when a diagnostic or therapeutic procedure is performed unless a modifier 25 is appropriately applied, (i.e., when a separate and significant E/M service beyond usual peri-procedure care was rendered by the same physician on the same day as the procedure).

H. UHA does not reimburse separately for collection of blood samples or lab handling when billed with E/M, preventative, or office-based lab codes.

I. UHA does not reimburse separately for digital rectal exams (G0102) when performed in conjunction with comprehensive or preventative service.

J. UHA follows CMS policy, including the use of modifier 24 with supporting documentation, when paying for any E/M codes during major or minor global periods.

K. The auto population of fields in an electronic or template-based health record does not by itself support upcoding of billable care.
   1. Documentation is considered cloned when each entry in the medical record for a patient or patients is worded exactly alike. It would not be expected that multiple patients nor the same patient on multiple visits would have the exact same problem and/or symptoms, same exam findings, same ROS, nor would they require the exact same treatment.
   2. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. Identification of this type of documentation will lead to denial of services for lack of medical necessity and possible recoupment of overpayments.

L. UHA does not allow separate payment for hospital outpatient services (rev code 0510) in addition to the usual E/M level of reimbursement when this service is provided in a physician's office setting.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. When billed with an E/M code, rev code 0510 is not separately reimbursed. These services are paid under the professional fee schedule.

B. Code G2211 is not separately reimbursed. These services are paid under the professional fee schedule.

IV. Administrative Guidelines

A. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria and to ensure proper reimbursement is made.

B. When submitting E/M codes based on time spent counseling and/or coordinating care, counseling provided must be in accordance with the CPT definition of counseling.

1. The following information must be documented in the medical record. If upon review the necessary information is not present, UHA may re-code the visit according to the key components present according to the medical record.

    a. Counseling topics and how time was spent coordinating the patient's care

    b. Total encounter time

    c. Total counseling and/or coordination of care time

C. Medical records which are illegible cannot be used to validate services billed. Therefore, if records are illegible, those services will not be considered for payment.

D. UHA Health Care Services department will work to avoid unnecessary delays in authorizations or medical reviews because the department understands that this can exacerbate stress levels in both patients and providers. Direct communication, extended availability and care coordination will serve to streamline the necessary administrative duties of the department. UHA will act purposefully to mitigate events which might interrupt or delay treatment regimens when evidence exists that such timing is of genuine therapeutic import.

V. Claims Filing Information

A. When billing for office consultation, indicate the "referred from" provider (last name, first name, middle initial) in block 17 of the CMS 1500 claim form. As needed, UHA may request consultation reports or supporting documentation from physicians.

VI. Policy History

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