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Evaluation and Management Overcoding
(Effective March 3, 2025)

Evaluation and Management (E/M) coding is an area the Centers for Medicare & Medicaid Services (CMS) has identified as having significant error rates. 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 educate practitioners on coding and documentation for E/M services, and to develop programs to review E/M services reported by high-coding practitioners.

E/M services are visits performed by physicians and non-physician practitioners to assess and manage a patient's health. Providers should report E/M services in accordance with the American Medical Association's (AMA's) CPT Manual E/M documentation criteria and CMS guidelines for reporting E/M service codes. Complete medical record documentation is the foundation of every patient's health record and can significantly affect claim coding and adjudication.

Accurate coding translates clinical documentation into uniform diagnostic and procedural data sets and provides the details of the services reported and rendered to the patient. Each E/M service provided should be carefully documented according to CMS guidelines, "Documentation Guidelines for Evaluation and Management."

To maintain correct coding, the implementation of the E/M Overcode program supports nationally recognized and accepted coding policies and practices. The program will evaluate the appropriateness of high-level E/M service levels to ensure consistency. Based on the outcome of this evaluation, the reimbursement may be adjusted.

AMA CPT's E/M Guidelines for Office and Outpatient Services

Evaluation and Management CMS coding guideline changes were effective January 1, 2021, and these changes only apply to Evaluation and Management services for Office and Outpatient services (99202-99215). All other Evaluation and Management services should follow newly updated guidelines per the 2023 and 2024 updates from CMS and AMA.

Overview of E/M Overcode Program

- Evaluates and reviews only high-level office and outpatient E/M services based upon diagnostic information that appears on the claim and/or other claim data relevant to the same episode of care.
- Identifies outlier providers who consistently overcode E/M services.
- Applies the relevant E/M policy and recoding of the claim line to the corrected E/M level of service based on the intensity of the diagnostic, claim, and patient history data.
    - Note, the E/M will never be leveled lower than a level 3 and will only be applied to those claims from providers identified as outliers.

- Allows appropriate reimbursement prior to payment for the highest level E/M service code level for which the criteria are satisfied based on our comparative peer risk adjustment process.

Appeals:
If a provider disagrees with a determination, they have the right to file an appeal in accordance to the Provider Administration Manual guidelines. The appeal should be submitted with the 24PED2880051 Addendum PDF 24PED2880051 Addendum PDF medical record documenting the details of the E/M service. The medical record will be reviewed to assess the intensity of service and complexity of medical decision-making for the E/M services provided.

- 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 documentation in the medical record should support the CPT and ICD codes reported on the health insurance claim form.
- Careful documentation and coding of services rendered by following CMS and AMA guidelines is essential. More information is available in the CMS Evaluation and Management Services Guide, found on their website.