Magellan HEALTHCARE

Follow E/M coding guidelines for proper payment

Payment denials may occur when documentation doesn't support the claim

Evaluation and Management-specific tips

- Patients with psychiatric diagnoses may receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician (or other qualified healthcare professional).
    - **To report both E/M and psychotherapy, the two services must be significant and separately identifiable** (within the same progress note is acceptable).
    - **Documentation must support the add-on psychotherapy in addition to the E/M service.**

- **Time spent providing counseling and coordinating care may not be used to determine the level of E/M service** when E/M is performed in addition to psychotherapy.
    - For psychiatrists and qualified health care professionals who provide E/M services along with psychotherapy, **determine the appropriate E/M code by the level of the medical decision making (MDM)**.
    - To qualify for a level of MDM, two of the three elements for that level must be met or exceeded.
    - Do not base the selection of the E/M service on the number of diagnoses a patient has or the overall complexity of the patient's physical and psychiatric illnesses.
    - Simply listing current medications is *not* considered "prescription drug management."

- When billing, **select codes that best represent the services rendered during the patient's visit**.
    - Ensure that the submitted claim accurately reflects the services provided.
    - Ensure that medical record documentation supports the level of service reported.
    - Do not use the volume of documentation (the amount written or carried over from previous visits) to determine which specific level of service to bill.

Documentation guidelines

Required for all behavioral healthcare services

- A complete and legible medical record.
- Medical record entries that are made on the date of service, and include the following for each encounter:
    - Full name of member on each page, with exception of family therapy
    - Date of service on each page
    - Start and stop times, or total time of session for time-based codes
    - Descriptive documentation of therapeutic interventions

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- Patient progress and response to treatment
- Legible signature for each entry, which includes practitioner’s first name, last name and credentials
- Treatment plan that includes ongoing progress and progress to date, including:
    - Diagnosis revisions
    - Treatment changes
- HIPAA codes (both diagnosis and procedure) that are supported by the documentation presented in the medical record.