Evaluation and Management Reviews

Humana, or its designee, has the right to conduct reviews of healthcare providers' records related to services rendered to Humana-covered patients in certain circumstances. Humana requests access to medical records and billing documents periodically to conduct reviews. Upon request, the healthcare provider should be able to provide medical records to support the supplies and services billed.

These reviews confirm that:

- The most appropriate and cost-effective services were provided.
- The records and/or documentation substantiate the setting or level of service provided to the patient.

Why are we sharing this information?

Our members' health is in your hands. That is why Humana is committed to supporting your practice with training resources, policy updates, and industry-leading patient care programs.

What are reviewers looking for?*

- Records and/or documentation to support the setting or level of service provided to the patient.
- Records reviewed for type of history and examination; medical decision making; counseling and coordination of care (if any); nature of presenting problem; and time (2021 CPT Guidelines 99202-99205, 99212-99215).

Records needed to conduct the review:*

- Medical notes to support the setting or level of service provided to the patient.
- Procedure notes for services billed with evaluation and management (E/M) codes.

Service codes reviewed:*

- All high-level E/M codes
- All high-level emergency rooms services and examinations with moderate to complex medical decision making.
  (99205, 99215, 99220, 99223, 99226, 99233, 99236, 99425, 99255, 99285, 99291-99292)

Things to note:

Types of reviews:

Prepayment reviews

- The goal is to pay it right the first time and decrease post-pay reviews, which leads to improved patient and provider experiences.

Post-payment reviews

- Performed after claim payment depending on contractual agreement (based on materials and codes and not all inclusive).

Documentation requirements:

- Medical record should be complete and legible.
- Documentation of each patient encounter should include the reason for encounter, relevant history and examination, diagnostic results, diagnosis and medical plan of care.
- Appropriate health risk factors should be identified.
- The Diagnosis and treatment codes reported on billing statement should be supported by documentation in the medical record.

Provider References:

- Current year current procedural terminology (CPT) book
- 1995 or 1997 medical documentation guidelines
- Local coverage determination (LCD)
- National coverage determination (NCD)
- CMS guidelines
- American Medical Association Guidelines
- Humana's payment policies, at Humana.com/claimpaymentpolicies
- Additional claim dispute instructions at Humana.com/publications

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* The above is merely a reference and used as examples of but should not be considered all inclusive.