EVALUATION AND MANAGEMENT SERVICES

Origination: 3/2021
Last Review: 8/2024

Description

Evaluation and Management (E/M) codes represent the services performed in evaluating and managing member health. Office or hospital visits, preventative exams, and consultations are just a few examples of E/M services. These services often have varying code levels depending on the complexity as described by Current Procedural Terminology (CPT®). Evaluation and management services (E/M) must adhere to the criteria outlined in the current version of the CPT® manual. Please see current CPT® manual for guidance and criteria for coding and documenting the appropriate Evaluation & Management levels.

There are times where a member will be seen by a provider or group practice more than once per day for Evaluation and Management (E/M) services. A single code should typically be reported for all related E/M services a member is provided each day. Physicians and/or other qualified health care providers in the same group practice should select the appropriate code level representative of the cumulative related services.

Blue Cross NC may verify whether services are related or truly separate and significant. Review criteria includes, but is not limited to, diagnoses, claim history, and medical records.

Same group practice is defined as a physician and/or other qualified health care professional of the same specialty with the same Federal Tax ID number.

Same specialty is defined by primary specialty. Physician and/or other qualified health care provider subspecialty is not taken into consideration when determining eligibility for reimbursement.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will reimburse for E/M services according to the criteria outlined in this policy.

Reimbursement Guidelines

Codes listed in chart below are provided as examples. Actual codes include, but are not limited to, the examples provided.

Scenarios for same day, same member, same practice and specialty	**Related E/M Services** *(E/M categories defined by levels of service)*	**Problem Oriented E/M Service** (CPT® 99202-99215)	**Preventative Medicine Service** (CPT® 99381-99397)	**Annual Wellness Visit** (HCPCS G0438, G0439)	**Screening Services** (HCPCS G0101, G0102, Q0091)
Related E/M Services *(E/M categories defined by levels of service)*	One (1) cumulative **E/M service** reimbursable per day for **related** services				
Problem Oriented E/M Service (CPT® 99202-99215)		One (1) cumulative **E/M service** reimbursable per day for **related** services	**Problem Oriented E/M Service** (99202-99215) is reimbursed at up to 50%	**Problem Oriented E/M Service** (CPT® 99202-99215) is reimbursed at up to 50%	**Screening Services** (HCPCS G0101, G0102, Q0091) are not separately reimbursable
Preventative Medicine Service (CPT® 99381-99397)		**Problem Oriented E/M Service** (CPT® 99202-99215) is reimbursed at up to 50%		**Annual Wellness Visit** (HCPCS G0438, G0439) is not separately reimbursable	**Screening Services** (HCPCS G0101, G0102, Q0091) are not separately reimbursable
Annual Wellness Visit (HCPCS G0438, G0439)		**Problem Oriented E/M Service** (CPT® 99202-99215) is reimbursed at up to 50%	**Annual Wellness Visit** (HCPCS G0438, G0439) is not separately reimbursable		**Screening Services** (HCPCS G0101, G0102, Q0091) are not separately reimbursable
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- **If:** Multiple **related E/M Services** on same date of service for same member by same group practice
    - **Then:** One (1) cumulative **E/M service** reimbursable per day

  Reimbursement for multiple Evaluation & Management (E/M) codes performed for the same member by the same provider or group practice will be limited to one E/M service per date of service using the appropriate code level representative of the cumulative related services. This applies to E/M categories defined by levels of service. Please reference CPT® and HCPCS manuals for complete listing of E/M categories.

- **If: Preventative Medicine Service** (CPT® 99381-99397) **+ Annual Wellness Visit** (HCPCS G0438, G0439)
    - **Then: Annual Wellness Visit** (HCPCS G0438, G0439) is not separately reimbursable

  Annual wellness visits are not eligible for reimbursement when performed on the same day as preventative medicine services for the same member by the same provider or group practice.

- **If: Problem Oriented E/M Service** (CPT® 99202-99215) **+ Annual Wellness Visit** (HCPCS G0438, G0439) or **Preventive Medicine Service** (CPT® 99381-99397)
    - **Then: Problem Oriented E/M Service** (CPT® 99202-99215) is reimbursed at up to 50%

  Problem oriented E/M services performed for the same member by the same provider or group practice on the same day as wellness or preventative exams require a Modifier 25 for reimbursement. Problem oriented E/M services representing a significant and separately identifiable service appended with Modifier 25 will receive 50% reimbursement. This reduction in reimbursement is due to duplicate and overlapping professional practice expenses, such as; scheduling of appointments, use of exam room and equipment, and obtaining vital signs.

- **If: Annual Wellness Visit** (HCPCS G0438-G0439), **Preventive Medicine Service** (CPT® 99381-99397) or **Problem Oriented E/M Service** (CPT® 99202-99215) **+ Screening Services** (HCPCS G0101, G0102, Q0091)
    - **Then: Screening Services** (HCPCS G0101, G0102, Q0091) are not separately reimbursable

Screening services performed for the same member by the same provider or group practice on the same day as annual wellness, preventative medicine and/or problem-oriented E/M services are not eligible for separate reimbursement regardless of Modifier 25 usage.

After Hours Care

Services provided on weekends or holidays, or between 10pm to 8am at a facility that normally provides 24-hour services are considered mutually exclusive to an ED visit.

Claims for afterhours care reported with CPT® 99050 and 99051 are considered mutually exclusive to any service(s) provided at an urgent care center and are not separately reimbursable to facilities credentialed and contracted as an urgent care center.

After hours codes (CPT® 99050 and 99051) are not separately reimbursable when performed on the same day as preventative medicine services (CPT® 99381-99397) for the same member by the same provider or group practice.

Consultations

Interprofessional telephone/internet consultation services are provided by a consulting physician at the request of the patient's primary or treating physician to assist in the diagnosis and/or management of the patient's problem without a face-to-face encounter with the consultant. 99446, 99447, 99448, 99449, 99451, 99452 are considered incidental and not eligible for separate reimbursement.

In accordance with CMS, Blue Cross NC will no longer separately reimburse for office/outpatient consultation codes (CPT® codes 99241–99245) and inpatient consultation codes (CPT® codes 99251–99255). Consultation services should be reported with an appropriate office/outpatient or inpatient E/M code representing the location where the visit occurred and the level of complexity of the visit performed, such as code ranges 99221-99223, 99304-99306, and 99202-99215.

Durable Medical Equipment Determination

Physician documentation of face-to-face visit for durable medical equipment determination performed by nurse practitioner, physician assistant or clinical nurse specialist (HCPCS G0454) is considered **incidental** to the evaluation and management service and is not eligible for separate reimbursement.

Hospital Discharge Day

Only one hospital discharge day management service (CPT® 99238-99239) will be reimbursed per patient per hospital stay according to CMS policy. Additionally, only the attending physician is to report the discharge day management service. Subsequent hospital discharge day management services will not be eligible for reimbursement after the initial claim for that service has been processed for the same date of service.

Immunization Administration

Evaluation and Management services will not be reimbursed separately when billed with immunization administration codes CPT® 90460 – 90474. If a significant, separately identifiable evaluation and management service is performed in addition to immunization administration, Modifier 25 must be used. (See also Commercial Reimbursement Policy titled "Immunization Guidelines").

Medical Records Copying Fee

Medical records copying fee, administrative (HCPCS S9981) and medical records copying, per page (HCPCS S9982) are considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and not eligible for separate reimbursement.

Modifier 25

Modifier 25 is used to indicate that a significant and separately identifiable E/M service was performed on the same day of service for an unrelated problem by the same provider or group practice within the same specialty.

Blue Cross NC interprets the definition of 99211, which includes "minor", to be incompatible with the definition of Modifier 25, which includes "significant". 99211 appended with Modifier 25 is not reimbursable.

Evaluation and management services performed the same day as a 0 or 10-day global medical or surgical service will be denied as included in the global surgical package, unless the service was significant and separately identifiable from the minor procedure and is indicated with Modifier 25.

E/M services (CPT® 99202-99215, 99221-99223, 99231-99233, 99460) are included as part of critical care services (CPT® 99291) provided by the same provider or same group practice on the same day in the same place of service unless shown to be significant and separately identifiable.

E/M services are considered inherent to any cardiovascular service billed on the same day. Therefore, E/M services will not be eligible for reimbursement when billed on the same day as a cardiovascular service unless shown to be significant and separately identifiable.

Peak expiratory flow rate (S8110) is considered a part of any E/M or physician service codes and will not be eligible for separate reimbursement unless shown to be a distinct and separately identifiable service.

Consistent with guidance from the American Association of Neuromuscular and Electrodiagnostic Medicine, Electromyographic (EMG) test, nerve conduction study (NCS), blink reflex test, or neuromuscular junction (NMJ) testing should not be billed on the same day as E/M services according to expert panel guidance. Therefore, E/M services will not be eligible for reimbursement unless shown to be distinct and separately identifiable.

Note: Use of Modifier 25 is not appropriate to report two or more E/M services when one or more of the E/M codes include "per day" in its definition.

New Visit Frequency

Blue Cross NC does not automatically reassign or reduce the code level of Evaluation and Management codes billed for covered services, with the exception of the new visit frequency editing as described here.

A member who has received any professional (E/M or other face-to-face) services from a provider within the same group practice (same specialty) within the **previous 3 years** is no longer considered a new patient when billing Evaluation and Management codes.

When a claim is received reporting a new patient evaluation and management service that does not meet the definition above, the new patient evaluation and management service code will be replaced with the equivalent established patient evaluation and management code if one is available. Otherwise, the claim will be denied.

Observation Care Services

According to CMS, reimbursement for the initial observation care codes and subsequent observation care code codes encompass the full scope of care provided by the physician who ordered the hospital observation services. The applicable code can only be reported once per day and only by the admitting/ordering provider.

Consistent with CMS and CPT® guidance, initial observation care codes and codes that include the initial observation care are only reimbursable on the first day of treatment and are not intended to be billed on subsequent days of the observation care. Likewise, subsequent observation care codes will be reimbursable on each additional day of the observation stay and only by the admitting/ordering provider.

Other physicians or qualified healthcare professionals shall not report observation services (initial or subsequent) and are to bill the applicable outpatient service codes should they render any consultations, evaluations, or additional services during the member's observation stay.
Observation care discharge services are not separately reimbursable in any of the scenarios below:

- Another observation service (initial or subsequent) is submitted for the same date of service.
- Member is admitted to inpatient for the same date of service
- No evidence of member being in an observation stay within three days prior

Physical, Occupational, and Speech Therapy Providers

Evaluation and Management codes (CPT® 99202-99215 and 99241-99245) are not eligible for reimbursement when the rendering provider is a physical therapist, occupational therapist, speech therapist, or an assistant thereof. Evaluative services would be submitted using the appropriate therapy evaluation codes, such as 97161-97164, 97165-97168, or 92521-92524.

Preventive Medicine Initial or Periodic Visit Frequency

Consistent with guidance from the American Academy of Pediatrics, reimbursement for preventative medicine services are limited to:

- Eight visits in a member's first year of life.
- Seven visits when a member is one to four years old

Prolonged Evaluation and Management Service

Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; first hour (CPT® 99358) and each additional 30 minutes (CPT® 99359) is considered **incidental** to all evaluation and management services, surgical services, and laboratory services and not eligible for separate reimbursement.

Resource Intensive Service

Resource intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit. Code HCPCS G0501 is considered incidental to the evaluation and management service and is not eligible for separate reimbursement.

Facility Charges with Office Evaluation and Management Services

Facilities are not eligible for reimbursement of office or clinic-based (051x, 052x, 076x) Evaluation and Management services. Professional reimbursement of office or clinic-based E&M services includes any technical or facility fees.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross NC web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Related Coding	Description
99202-99499	Evaluation and Management Services
051x, 052x	Clinic revenue codes
076x	Specialty services revenue codes
Modifier 25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

Related policy

Bundling Guidelines

Modifier Guidelines

Maximum Units of Service

Guidelines for Global Maternity Reimbursement

Status Codes

Telehealth

References

American Academy of Pediatrics AAP

American Association of Neuromuscular and Electrodiagnostic Medicine. AANEM

American Hospital Association Uniform Billing Guidelines

CMS Evaluation and Management Services

CMS Medicare Benefit Policy Manual - Chapter 15

CMS Medicare Claims Processing Manual Ch. 12

Current Procedural Terminology (CPT®) 2022 Professional Edition, by the American Medical Association

Optum 360. (2022) *Uniform Billing Editor*.

BlueCross BlueShield of North Carolina

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Commercial Reimbursement Policy

History

6/1/21	New policy developed. Blue Cross Blue Shield North Carolina (Blue Cross NC) will limit reimbursement for E&M services according to the guidelines outlined in this policy. Medical Director review 3/2021. **Policy noticed 3/31/2021 for effective date 6/1/2021.** (eel)
7/27/21	Treatment Rooms with Office Evaluation and Management Services clarification added. (eel)
10/1/21	Clarified "**Treatment Rooms with Office Evaluation and Management Services**". References updated. (eel)
12/30/21	Routine policy review. Grammatical corrections. Medical Director approved. (eel)
1/21/22	"**After Hours Care**" section clarified for reimbursement of 99050 and 99051. (eel)
6/1/22	Policy language updated throughout. Added "Blue Cross NC may verify whether services are related or truly separate and significant. Review criteria includes, but is not limited to, diagnoses, claim history, and medical records." To Description section. Reimbursement Guidelines Modifier 25 section updated, including "Blue Cross NC interprets the definition of 99211, which includes, "minor" to be incompatible with the definition of Modifier 25, which includes "significant"." Hospital Discharge, Preventative Medicine, and Observation Care Services sections added to Reimbursement Guidelines. Medical Director approved. **Policy noticed 3/31/2022 for effective date 6/1/2022.** (eel)
7/26/22	Added "Physical, Occupational, and Speech Therapy Providers**"** section to Reimbursement Guidelines. Medical Director approved. **Policy noticed 5/17/2022 for effective date 7/26/2022**. (eel)
8/9/22	Clarification to **Immunization Administration**, Modifier 25 must be used with all evaluation and management services when reporting a significant, separately identifiable service in addition to the immunization services. (ckb)
10/11/22	Effective 9/8/2022, Problem oriented E/M services are eligible for 50% reimbursement when submitted on the same date of service as Preventative Medicine or Annual Wellness encounter. (eel)
11/1/22	Reimbursement Guidelines alphabetized and added "Consultations" section with language updated throughout. Blue Cross NC will no longer separately reimburse for office/outpatient and inpatient consultation codes. Moved Interprofessional Consults language from **Bundling Guidelines Policy**. Medical Director approved. **Policy noticed 9/1/2022 for effective date 11/1/2022.** (ckb)
12/31/22	Routine policy review. Minor Revisions Only. (ckb)
1/1/24	Revenue Code policy reference added to Treatment Rooms section. No change to policy intent. (tlc)
11/1/24	Facility charges reimbursement guidelines added; separate reimbursement is not allowed. RPOC approved. **Policy noticed 09/1/24 for effective date 11/1/24**

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

BlueCross BlueShield of North Carolina

Commercial Reimbursement Policy

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.