EVALUATION AND MANAGEMENT SERVICES

Origination: 6/2022
Last Review: 05/2024

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 record.

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

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

Actual codes include, but are not limited to, the examples provided below.

- **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 physician and/or other qualified health care provider in the same group practice within the same specialty 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: Preventive Medicine Service** (CPT 99381-99397) **+ Annual Wellness Visit** (HCPCS G0438-G0439)
    - **Then: Preventive Medicine Service** (CPT 99381-99397) is reimbursed at 50%
- **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%

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

Screening services performed for the same member by the same physician and/or other qualified health care provider in the same group practice within the same specialty on the same day as annual wellness and/or problem-oriented E/M services are not eligible for separate reimbursement regardless of Modifier 25 usage.

Modifier 25

Modifier 25 is used to indicate that the evaluation and management service was significant and separately identifiable from a minor procedure performed on the same day.

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 on the same day in the same place of service unless shown to be significant and separately identifiable.

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 physician or 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.

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 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 day management service is only to be billed on a day other than the initial day of observation. Additionally, providers are not to bill this code separately when the member has been admitted to inpatient status from observation status.

Hospital Discharge Day

Only one hospital discharge day management service (CPT® 99238-99239) will be allowed 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 Reimbursement Policy titled "Immunization Guidelines"). For information specific to Covid-19 vaccine administration, see the provider news article under "COVID-19 Support Measures: Details and Coding Guidance."

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.

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.

Treatment Rooms with Office Evaluation and Management Services

Revenue code 0761 (treatment room) representing office or clinic-based Evaluation and Management services (CPT® 99202-99215, 99241-99245, HCPCS G0463) is not reimbursable. Per UB-04 manual and Uniform Billing Editor, revenue code 0761 should only be used to represent Specialty Services, such as when a specific procedure has been performed or treatment has been rendered.

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.

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.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com.

CPT® Code / Modifier	Description
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

Status Codes

References

CMS Evaluation and Management Services

CMS Medicare Benefit Policy Manual - Chapter 15

CMS Medicare Claims Processing Manual Ch. 12

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

Centers for Medicare and Medicaid Services. CY 2021 Physician Fee Schedule Final Rule. https://public-inspection.federalregister.gov/2020-26815.pdf. Accessed March 1, 2021

Optum 360. *Uniform Billing Editor*.

American Hospital Association. (2021) *Official UB-04 Data Specifications Manual* (2022 ed.)

History

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
12/31/2022	Routine policy review. Minor Revisions only. (cjw)
11/1/2023	Removed language regarding codes 99381 – 99397. Medical Director approved. **Notification on 11/1/2023 for effective date 1/1/2024.** (tlc)
05/1/2024	Problem-oriented and Preventive E/M services are eligible for up to a 50% reimbursement when submitted on the same date of service as an annual wellness visit. RPOC approved. **Notification on 5/01/2024 for effective date 7/10/2024.** (tlc)

Application

BlueCross BlueShield of North Carolina

Medicare Reimbursement Policy

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) 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 Member’s group contract and subscriber certificate that is in effect at the time services and/or supplies 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.