EVALUATION AND MANAGEMENT SERVICES

File Name: Evaluation_and_management_services
Origination: 3/2021
Last Review: 1/2022
Next Review: 12/2022

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.

Related services are defined by a 3 character diagnosis match.

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 limit reimbursement for E/M services according to the guidelines outlined in this policy.

Reimbursement Guidelines
<table>
<thead>
<tr>
<th>Scenarios for same day, same member, same practice and specialty</th>
<th>Related E/M Services (Within each E/M category defined by levels of service)</th>
<th>Problem Oriented E/M Service (CPT® 99202-99215)</th>
<th>Preventative Medicine Service (CPT® 99381-99397)</th>
<th>Annual Wellness Visit (HCPCS G0438, G0439)</th>
<th>Screening Services (HCPCS G0101, G0102 and Q0091)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related E/M Services (Within each E/M category defined by levels of service)</td>
<td>One (1) cumulative E/M service reimbursable per day for related services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Oriented E/M Service (CPT® 99202-99215)</td>
<td>One (1) cumulative E/M service reimbursable per day for related services</td>
<td>Problem Oriented E/M Service (99202-99215) is reimbursed at up to 50%</td>
<td></td>
<td></td>
<td>Screening Services (G0101, G0102 and Q0091) are not separately reimbursable</td>
</tr>
<tr>
<td>Preventative Medicine Service (CPT® 99381-99397)</td>
<td></td>
<td>Problem Oriented E/M Service (99202-99215) is reimbursed at up to 50%</td>
<td>Annual Wellness Visit (G0438, G0439) is not separately reimbursable</td>
<td></td>
<td>Screening Services (G0101, G0102 and Q0091) are not separately reimbursable</td>
</tr>
<tr>
<td>Annual Wellness Visit (HCPCS G0438, G0439)</td>
<td></td>
<td></td>
<td>Annual Wellness Visit (G0438, G0439) is not separately reimbursable</td>
<td></td>
<td>Screening Services (G0101, G0102 and Q0091) are not separately reimbursable</td>
</tr>
<tr>
<td>Screening Services (HCPCS G0101, G0102 and Q0091)</td>
<td></td>
<td>Screening Services (G0101, G0102 and Q0091) are not separately reimbursable</td>
<td>Screening Services (G0101, G0102 and Q0091) are not separately reimbursable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- **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 within each E/M category 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 physician and/or other qualified health care provider in the same group practice within the same specialty.

- **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 physician and/or other qualified health care provider in the same group practice within the same specialty 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 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, preventative medicine 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.

The Modifier 25 will not be recognized with CPT® 99211 performed on the same date as a preventive medicine visit (CPT® 99391 - 99397).

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.

New Visit Frequency

BCBSNC 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.

Office/Outpatient Consultations

BCBSNC will replace a code billed for a subsequent office or other outpatient consultation within 6 months of the initial office or other outpatient consultation by the same provider for the same member with the appropriate level of established office visit. The crosswalk is as follows:

- 99241 to 99212
- 99242 to 99212
- 99243 to 99213
- 99244 to 99214
- 99245 to 99215

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 after hours 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 physician and/or other qualified health care provider in the same group practice within the same specialty.

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. The 25 Modifier is not required with Preventive Medicine Services CPT® 99381 – 99397. (See also Commercial 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.

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.

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. Follow CPT® and HCPCS guidelines when submitting prolonged service codes.

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.

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.

Rationale

Following CPT® and CMS guidance, Modifier 25 is appropriate to indicate a significant and separately identifiable E/M service by the physician or other qualified health care provider in the same group practice and same specialty provides a separate E/M service on the same day for an unrelated problem.

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 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.

<table>
<thead>
<tr>
<th>CPT® Code / Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202-99499</td>
<td>Evaluation and Management Services</td>
</tr>
<tr>
<td>Modifier 25</td>
<td>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</td>
</tr>
</tbody>
</table>

Related policy

- Bundling Guidelines
- Modifier Guidelines
- Maximum Units of Service
- Guidelines for Global Maternity Reimbursement
- Status Codes
- Telehealth

References


History
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)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/27/21</td>
<td>Treatment Rooms with Office Evaluation and Management Services clarification added. (eel)</td>
</tr>
<tr>
<td>10/1/21</td>
<td>Clarified “Treatment Rooms with Office Evaluation and Management Services”. References updated. (eel)</td>
</tr>
<tr>
<td>12/30/21</td>
<td>Routine policy review. Grammatical corrections. Medical Director approved. (eel)</td>
</tr>
<tr>
<td>1/21/22</td>
<td>“After Hours Care” section clarified for reimbursement of 99050 and 99051. (eel)</td>
</tr>
</tbody>
</table>

**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.

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.

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield symbols are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. All other marks and trade names are the property of their respective owners. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.