AmeriHealth Caritas Louisiana

Evaluation and Management

Reimbursement Policy ID: RPC.0066.2100

Recent review date: 08/2024

Next review date: 11/2025

AmeriHealth Caritas Louisiana reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Louisiana may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including but not limited to Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM). Other factors that may affect payment include but are not limited to medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other policies. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all healthcare services billed on a CMS-1500 form or its electronic equivalent, and, when specified, billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines AmeriHealth Caritas Louisiana reimbursement criteria for Evaluation and Management (E/M) services reported on claim form CMS-1500.

Exceptions

Evaluation and management services claims submitted to AmeriHealth Caritas Louisiana on form CMS-1450 are excluded from this policy.

Reimbursement Guidelines

Established patient
An established patient is one who has received face-to-face professional services from the same individual physician or other qualified health care professional in the last three (3) years.

Evaluation and Management
Evaluation and management (E/M) codes represent services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient's health. Procedures such as diagnostic tests, radiology, surgery and other particular therapies are not considered evaluation and management services.

Modifier 25 – Significant, separately identifiable E/M
Modifier 25 indicates a 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. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Prolonged services
Prolonged services are for additional care provided to a beneficiary after an evaluation and management (E/M) service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion E/M service.

Same individual physician or other qualified health care professional
Any physician or other health care professional from the same group practice with the same specialty and subspecialty reporting under the same Federal Tax Identification number (TIN).

Definitions

Established patient
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Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and associated publications and services.
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI) in Medicaid.
VI. Applicable Louisiana Medicaid Fee Schedule(s).
VII. Office of Inspector General (OIG).
VIII. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000115.asp#:~:text=Prolonged%20services%20are%20for%20additional,usual%20companion%20E%2FM%20service

Attachments

N/A

Associated Policies

RPC.0008.2100 Telehealth
RPC.0009.2100 Significant, Separately Identifiable Evaluation and Management Service (Modifier 25)

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
08/2024	Reimbursement Policy Committee approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added
	Precedes Act 319