

Evaluation and Management

Reimbursement Policy ID: RPC.0066.2100

Recent review date: 11/2025

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. The health plan 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 the health plans reimbursement criteria for Evaluation and Management (E/M) services reported on claim form CMS-1500.

Exceptions

Evaluation and management services claims submitted to the health plan on form CMS-1450 are excluded from this policy.

Reimbursement Guidelines

The health plan reimbursement for Evaluation and Management (E/M) Services aligns with CPT Evaluation and Management (E/M) Services Guidelines and applicable Centers for Medicare and Medicaid Services (CMS) requirements.

New patient vs. established patient

Consistent with CPT Evaluation and Management (E/M) Services Guidelines, the health plan considers “new patient” (99202-99205) E/M services eligible for reimbursement when the member has received no professional services from the same physician or any other health care professional with the same specialty and subspecialty in the same group practice that bills under the same Federal Tax Identification number (TIN) within the past three (3) years. Evaluation and Management Services to members who have received professional service(s) from either the same provider or any same-specialty provider in the same practice during the past three years must be reported with an appropriate “established patient” (99212-99215) E/M code.

The initial pre-natal visit of each new pregnancy is considered a new patient.

Problem-focused visits

Problem-oriented E/M services involve treatment, diagnosis, or assessment of an illness, symptom, or other complaint or concern, regardless of whether a definitive diagnosis is made during the patient encounter. Except in rare circumstances, the health plan will consider one problem-focused E/M service by the same individual physician or other qualified health care professional to the same member on the same date for reimbursement.

Preventive care visits

Adults

The health plan will reimburse one annual Preventive Medicine E/M service for adult members. Providers should report an appropriate Preventive Care E/M code. See reimbursement policy RPC.0088.2100 Preventive Services for additional information.

Children

Pediatric Preventive Care E/M services are a component of the health plans Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, and are eligible for reimbursement in accordance with applicable health plans EPSDT guidelines. See reimbursement policy RPC.0094.2100 EPSDT

Multiple same-day E/M services (modifier 25)

During the course of a problem-focused or preventive care E/M service, if the provider finds and documents a separate problem requiring significant additional work and a distinct diagnostic and treatment approach, the health plan may consider for reimbursement one additional E/M service reported with Modifier 25.

Emergency department visits

In accordance with CMS and CPT Evaluation and Management (E/M) Services Guidelines, providers of E/M services in an Emergency Department setting should select the appropriate Emergency Department E/M Service code that corresponds to the level of services provided and that is supported in the medical record. Time is not a descriptive component for emergency department E/M levels of service. Providers must use CPT codes 99281-99285.

Hospital inpatient and observation E/M services

CPT categorizes professional E/M services for patients in a hospital inpatient or observation status according to the length of patient stay and whether admission and discharge occur on the same or different calendar

dates. Providers should select the appropriate CPT E/M code(s) using these criteria to receive accurate reimbursement from the health plan.

- Initial Hospital Inpatient or Observation Care CPT codes 99221-99223
- Subsequent Hospital Inpatient or Observation Care CPT codes- 99231-99233
- Admission and Discharge, Same Date 99234-99236

Discharge day E/M services

In alignment with CMS and CPT, the health plans discharge day E/M reimbursement includes all services performed on the day of discharge by the physician or other qualified health care professional from the same group practice under the same specialty and same Tax Identification Number (TIN). No additional E/M service will be reimbursed. Discharge day E/M CPT codes- 99238-99239

E/M services provided within global period

Based on global surgical package and split billing.

- The plan does not separately reimburse for any E/M service when reported with major surgical procedures.
- The plan does not separately reimburse for any E/M service when reported with minor surgical procedures with a 10-day post-op period.
- The plan may separately reimburse for new patient E/M services and E/M services described in CPT as applying to new or established patients when reported with minor procedures with a 0-day post-op period.
- The plan may consider reimbursement for an unrelated E/M service rendered by the same physician* during the global period if the appropriate modifier 24 is appended to the E/M procedure code.

*Same physician-Physicians in the same group practice who are in the same specialty must bill as though they were a single physician.

After Hours Care

Services provided in the office at times other than regularly schedule office hours, or days when the office is normally closed. Providers must bill place of service 11 and CPT 99050 or 99051.

Providers must bill place of service 72 for RHC, place of service 50 for FQHC, place of service 02 or 10 for Telehealth and place of service 20 for Urgent Care.

Critical care

Consistent with CMS and CPT Evaluation and Management (E/M) Services Guidelines, Critical Care E/M services are reported based on the provider's time spent delivering direct care to a critically ill or injured patient. Critical care procedure code is billed on an Outpatient ER claim when the patient is discharged to home.

- Critical Care first 30-74 minutes 99291
- Critical Care each additional 30 minutes (list in addition to primary service) 99292

Prolonged services

CPT Evaluation and Management (E/M) Services Guidelines include add-on codes for Prolonged E/M Services, both with and without direct patient care. For accurate reimbursement, providers should report Prolonged E/M Services (99417-99418) on the same claim as the primary E/M service. The health plan allows no reimbursement for prolonged E/M Services code billed without a primary E/M Services code on the same claim.

For accurate reimbursement, providers must report E/M services with the appropriate CMS Place of Service (POS) code.

Definitions

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).

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 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)

RPC.0012.2100 Global Surgical Package and Split Surgery
 RPC.0063.2100 Place of Service
 RPC.0088.2100 Preventive Services
 RPC.0094.2100 EPSDT

Policy History

10/2026	<ul style="list-style-type: none"> Removed the next review date Replaced the plan name with “the health plan”
11/2025	Reimbursement Policy Committee approval
08/2025	Annual Review <ul style="list-style-type: none"> Added Place of Service policy Added definition for Modifier 24 Added New and Established CPT codes Added Emergency dept CPT codes Added Hospital inpatient and Observation CPT codes Added Prolonged services CPT codes Added Discharged day CPT codes Added After hours CPT codes Added Critical Care CPT codes Added Preventive Services policy Added EPSDT policy
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
08/2024	Reimbursement Policy Committee approval
	Precedes Act 319