

## EVALUATION AND MANAGEMENT SERVICES

### Policy

NHP reimburses participating providers for the provision of medically necessary evaluation and management (E/M) services, which also includes specialist visits for second opinions.

### Policy Definition

NHP recognizes the most current version of the American Medical Association’s CPT descriptors of E/M codes, and instructions for selecting a level of service. Medical records documentation based on the 1995/1997 CMS documentation guidelines for E/M services must support reported levels of service.

### Prerequisites

#### Authorization, Notification and Referral

Service	Requirement
Specialty Visits	None
OB/GYN routine, preventive or urgent care for all plans	No referral, authorization, or notification required.
Outpatient and Diversionary Behavioral Health Services for all plans	No referral, authorization, or notification required.
For HVMA Members	A referral number for most specialists is required for NHP members with a Harvard Vanguard Medical Associates PCP seeking non-emergency care outside of the Harvard Vanguard Medical Associates Network. Please verify that the member has the appropriate referral number prior to rendering care.

### Limitations

Reimbursement is limited to E/M services physicians and qualified non-physician practitioners are legally authorized to perform in compliance with the Commonwealth of Massachusetts laws. A smoking and tobacco cessation counseling visit > 10 minutes is available and limited to a total of 16 visits per 12-month cycle

### Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

## Definitions

**Consultation Service:** A type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. When requested by a physician or other appropriate source, a consultation may be provided by a physician or qualified non-physician practitioner (NPP). In order to be a qualified NPP, performing a consultation service must be within the scope of practice and licensure in the state in which the NPP practices.

**Evaluation and Management Service:** Visits and consultations furnished by physicians and qualified non-physician practitioners practicing within the scope of practice and licensure in the state in which the NPP practices.

**Established patient:** A patient who has received professional services from the provider or another provider of the same specialty who belongs to the same group practice (same tax ID number) within the past three years.

**Global period:** Surgical procedures are assigned a global day period of 0, 10, or 90 day(s) by CMS based on the complexity of the procedure. Services related to the surgery, rendered within the assigned specified number of global days, including E/M services are considered inclusive to the primary procedure and are not eligible for separate reimbursement.

**ICF:** Intermediate care facility

**LTCF:** Long-term care facility

**New patient:** A patient who has *not* received any professional services from the same provider or another provider of the same specialty who belongs to the same group practice (same tax ID number), within the past three years.

**Office or other outpatient visit:** An evaluation and management (E/M) service with history, examination, and medical decision making considered as the key components, provided in the physician's office or in an outpatient or other ambulatory facility.

**Office or Other Outpatient-setting:** The physician's office or in an outpatient or other ambulatory facility where the patient is considered an outpatient until inpatient admission to a health care facility occurs.

**Physician Telephone Services:** Non-face-to-face E/M services provided by a physician to a patient using the telephone. Codes 99441, 99442, 99443, are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service, procedure, and visit. Likewise if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested, or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure.

**PCP:** Primary care provider

**Preventative medicine visit:** A comprehensive, preventative medical E/M of an individual including an age appropriate history, exam, counseling, anticipatory guidance, risk factor reduction intervention(s), and the ordering of laboratory and / or diagnostic procedures.

**Specimen handling:** The handling and /or conveyance of a specimen/device from the physician's office, or other setting, to a laboratory.

**SNF:** Skilled Nursing Facility

**Urgent Care provided at a NHP site:** Circumstances when services are provided by a NHP PCP; in the office at times other than regularly scheduled office hours, or on days when the office is normally closed; provided in the office during regularly scheduled evening, weekend, or holiday office hours; or provided on an emergency basis in the office that disrupts other scheduled office services.

## Neighborhood Health Plan Reimburses

### General E/M Services

- One professional E/M code per day, per specialty, per group.
  - A preventative medicine visit with a problem-oriented visit on the same day when modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) is appended to the problem-oriented E/M to indicate the service is distinct and separately identifiable. Documentation in the medical record must substantiate the unrelated, distinct and separately identifiable problem(s).
- New patient visits when the physician, or another physician of the same specialty, in the same group, has not seen the patient for three years.
- A new patient E/M service when reported with a minor surgical procedure with a 0-day post op period.
- Reimbursement will be considered for E/M services rendered during the global period if the appropriate modifier is appended to the E/M procedure code to indicate that the service rendered is distinct from the primary (global) procedure.

### Consultation E/M Services

- Office consultations reported with E/M office visit codes (99201-99205, 99211-99215).
- Inpatient consultations reported with initial hospital care codes (99221-99223) or subsequent hospital care codes (99231-99233) when the physician is face-to-face with the patient in the facility.
- Only one consultation service for opinion or advice relating to evaluation of a known or suspected problem, to a provider of the same specialty, in the same group (same tax ID number) on the same date of service, reported with the most appropriate office visit or hospital inpatient CPT code. Modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) must be appended to the E/M service.
  - NHP follows CMS guidelines with regard to no longer recognizing CPT consultation codes (99241-99245, 99251-99255).

### Telephone E/M Services

- Physician telephone services initiated by an established patient, parent, or guardian not originating from a related E/M service or procedure within the previous seven days and/or not leading to an E/M service or procedure within the next 24 hours.
- The telephone services must be documented in the medical record, including, but not limited to the nature and extent of the services rendered.

### **Services Rendered After Hours, on Weekends and Holidays**

- To promote the use of the member's primary care provider for urgent care, NHP will reimburse emergent/after hours/weekend and holiday care services. These should be rendered in the primary care provider's office, not in planned urgent care settings, or not for any other unscheduled appointments that do not fit into the criteria as defined by CPT codes 99050, 99051 or 99058.
- Documentation in the medical record must indicate that the patient presented with a medical condition manifested by symptoms of sufficient severity that could have resulted in placing the health of the individual in serious jeopardy, AND that the physician attended to the patient with immediacy, disrupting other services or duties the physician was performing at the time.

### **Neighborhood Health Plan Does *Not* Reimburse**

- E/M services within the global period of a procedure, as they are considered inclusive to the procedure.
- Established patient E/M services on the same day as a surgical procedure with a 0-day post op period unless there is a significant, separately identifiable E/M service, or above and beyond the usual preoperative and postoperative care associated with the procedure documented in the medical record and the appropriate modifier appended to the E/M code.
- Consultation codes (CPT 99241-99245, 99251-99255) which are no longer recognized by NHP.
- Inpatient consultations billed with 99221-99223, 99231-99233, when the consulting physician is not face-to-face with the patient in the facility, e.g. conducted via telephone, or video-conferencing.
- An emergency department E/M service billed with critical care services rendered by the same provider on the same date of service.
- Services identified by CPT as included in the descriptor of pediatric critical care services.
- Prolonged physician services (99354-99357) in the office or other outpatient setting.
- Prolonged physician service with or without contact (99358-99359)
- Electronic visits (e-visits) are not reimbursed at this time.
- Generic and/or special supplies are not reimbursed. (*Note:* Please submit the most specific HCPCS code for consideration.)
- Handling fees, device fees- considered part of the services/procedures rendered.
- Out-of-hospital on-call services.
- Adjunct codes reported in addition to the basic service rendered, including codes for medical services provided from 10:00 PM to 8:00 AM at a 24 hour facility (e.g. an emergency department); or out-of-the-office; or on an emergency basis out-of-the-office.
- Medical testimony, special reports or forms, or computer data analysis.
- Unusual physician travel.

- Moderate (conscious sedation)

### Procedures Codes Applicable to Guideline

*Note: This list of codes may not be all-inclusive.*

Category	CPT Codes	Short Descriptor	Comments
Office, Other Outpatient Services	99201-99205	Office or other outpatient visit-New Patient	
	99211-99215	Office or other outpatient visit-Established Patient	
Hospital Observation Services	99217-99220	Observation care	Please refer to the NHP Observation Provider Payment Guidelines
	99224-99226	Subsequent Day Observation Care	Not a covered benefit Please refer to the NHP Observation Provider Payment Guidelines
Inpatient Services	99221-99223, 99231-99239	Hospital Inpatient Services	
Consults	99241-99245	Office consultation E/M services	<b>Not reimbursed.</b> Report with the appropriate complexity level office visit or hospital inpatient E/M CPT code.
	99251-99255	Inpatient consultation E/M services	
Emergency Department Services	99281-99285	Emergency Department Services	Bill for unscheduled care rendered in the Emergency Department
	99288	Physician direction of advanced life support	Not reimbursed
Critical Care	99291-99292	Critical care	Bill initial service (30-74 minutes) on one line with a count of 1. Bill the number of units that represent each additional 30 minutes with 99292
Nursing Facility Services	99304-99310	Nursing facility care	Bill with the SNF, ICF, or LTCF authorization number
	99315-99316	Nursing facility discharge day	
	99318	Annual nursing facility assessment	
Domiciliary, Rest Home, Custodial Care Services	99324-99337	Domiciliary/Rest Home E/M	
	99339-99340	Domiciliary/Rest Home care supervision	
Physician Home Services	99341-99350	Physician home visit, new or established patient	
Prolonged Services	99354-99357	Prolonged services, beyond the usual service in addition to the designated E/M service	Not reimbursed
	99358-99359	Prolonged services without contact	

Physician Standby Services	99360	Physician standby services	Not a covered benefit
Anticoagulant Management	99363-99364	Anticoagulant management for an outpatient on warfarin	Submit for outpatient management, only. Do not submit an E/M or care plan oversight for this service during the reporting period
Medical Team Conference	99366-99368	Team conference w/wo patient by healthcare professional	Not a covered benefit
Preventative Medicine Services	99381-99387	Initial preventative E/M-New Patient	
	99391-99397	Periodic preventative E/M-Established Patient	
Counseling Risk Factor Reduction and Behavior Change Intervention	99401-99404	Preventative counseling, individual	
	99406	Smoking and tobacco cessation counseling visit 3- 10 minutes	16 visits, per member, per 12 month cycle
	99407	Smoking and tobacco cessation counseling visit > 10 minutes	
Non-Face-to-Face Physician Service	99441-99443	Telephone E/M service to patient, parent or guardian	
On-Line Medical Evaluation	99444	On-line E/M by physician	Not a covered benefit
Neonatal and Pediatric Critical Care	99466-99467	Pediatric critical care during inter-facility transport	Please refer to the NHP Newborn Care Provider Payment Guidelines
	99468-99469	Neonatal critical care, age < 28 days	
	99471-99472	Pediatric critical care, age 29 days through 24 months	
	99475-99476	Pediatric critical care, age 2-5 years	
Miscellaneous	36415	Routine blood draws	Not separately reimbursed with labs or E/M services
	36416	Capillary blood draw	Not reimbursed
	96040	Genetic counseling, 30 min	
Non-Face-to-Face Non-physician Services	98966-98968	Assessment and management phone call by non-physician healthcare professional	Not a covered benefit
Special Services, Procedures and Reports	99000, 99001	Specimen handling	Not separately reimbursed
	99002	Device handling	
	99026-99027	Hospital mandated on-call service, in or out-of-hosp	Not reimbursed
	99050, 99051	Medical services, after hours, weekend and holiday care	

99058	Office emergency care which disrupt other scheduled office services	Must submit office notes
99053, 99056, 99060	Medical services 10:00 PM-8:00 AM at 24 hr facility (such as ER), or out of office, or on emergency basis out of office	Not reimbursed
99070	Special Supplies	Not reimbursed; use specific HCPCS code for reimbursement consideration
99075	Medical testimony	Not reimbursed
99080	Special reports or forms	
99082	Unusual physician travel	
99090	Computer data analysis	
99143-99145, 99148-99150	Moderate sedation	
99173	Visual acuity screen	

**Provider Payment Guidelines and Documentation**

- Submit only one E/M service code per day, per physician specialty or group.
- Submit accurate CPT codes for E/M services provided in a PCP’s office for treatment of a pre-existing condition, a sick care visit or a preventative care visit.
- Submit the appropriate E/M service code for non-critical care patients in the critical care unit.
- Submit the most up to date industry-standard codes.
- Submit the most appropriate modifier, when necessary, with the corresponding CPT code.
- In the inpatient setting, the **principal physician of record** must append the alpha modifier “-AI” to the inpatient E/M code when reported. This modifier will identify the physician who oversees the patient’s care from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed.

**Pediatric Critical Care**

- Services identified by CPT as included in the description of these codes should not be billed separately.
- For critical care services provided to a child older than 24 months, bill critical care codes.
- Supporting documentation in the medical record, consistent with AMA guidelines, including but not limited to the necessity of the procedure(s), as well as the nature and extent of the services rendered, must be available for review. Any records supporting an appropriate history, physical exam, and progress notes must also be available for review.

**Related NHP Payment Guidelines**

NHP **Modifier** Provider Payment Guideline

NHP **Newborn Care** Provider Payment Guideline

NHP **Observation** Provider Payment Guideline

NHP **Preventive Services** Provider Payment Guideline

**References**

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MassHealth Physician Manual, Transmittal Letter PHY-111, dated 07/01/06, page 4-30/31: Tobacco Cessation Services

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2011/04/19 <i>Updated authorization grid, smoking cessation, new 2011 CPT codes, references</i>	
2011/07/08 <i>Corrected observation code numbers, updated NHP does not reimburse and code grid to include: 99354-99359, updated 99058 to require office notes</i>	
2011/08/29 <i>Corrected range 99221-99223, 99231-99239; 99147-99150 added to procedure code grid. Non-coverage of consult codes added. Reference to CMS MLM article re consultations, and modifier "AI" added.</i>	
2011/12/30 <i>Policy definition updated, corrected range 99148-99150, updated referral grid, related guidelines.</i>	
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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Neighborhood Health Plan utilizes McKesson’s claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the “appropriate set” of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Questions may be directed to Provider Network Management at [prweb@nhp.org](mailto:prweb@nhp.org)