Evaluation and Management Services

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Description

Evaluation and Management (E&M) codes represent the services performed in evaluating and managing a member's 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 the 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.

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

Oscar incorporates standards established by the Centers for Medicare and Medicaid Services (CMS), and the American Medical Association (AMA) for our Evaluation and Management (E&M) services reimbursement policy. All services should be coded to the appropriate level of care, as laid out in the CMS, and AMA guidelines. All E&M leveling should be able to be substantiated by medical records.

Reimbursement Guidelines

Modifiers

Code modifiers used for E&M services billing should be appropriate for the services rendered and should be able to be supported by medical records. Oscar may verify modifier appendage by requesting medical records, review of diagnosis, and claim history to ensure that included modifiers adhere to the standards outlined by the CMS, and AMA (ex. 25, FS).

Split or Shared E&M Visits (Facility/Institutional)

Use modifier FS on claims to report split or shared services. This tells us that even though you're submitting the claim under 1 provider's NPI, more than 1 provider performed the visit. Payment will be made to the practitioner who performs the substantive portion of the visit. Substantive portion means more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

Multiple Visits Per Day

Oscar will reimburse one Evaluation and Management service visit per billing group, per subspecialty, per day. If both preventive and problem-oriented services are billed, and the problem-oriented visit is billed with modifier 25, Oscar will reimburse the higher-valued procedure at 100% of the otherwise allowable amount and the lower-valued procedure at 50% of the contracted rate. Minor problem-oriented visits and problem-oriented codes billed **without** modifier 25 will not be reimbursed. Other E&M Services will be paid at 100% when billed with modifier 25, unless addressed below.

Screening/Counseling/Nutrition Therapy/Prolonged Services/Overlapping E&M Services

If a screening, counseling, nutrition therapy, prolonged, or otherwise overlapping E&M service is coded with modifier 25 or 59, as appropriate, and billed on the same day as a preventive E&M service as defined in the coding section below, Oscar will reimburse 50% of the otherwise allowable amount for the non-preventative service. Otherwise, these services are not separately payable when billed on the same day as preventive E&M services by the same provider.

Examples of and exceptions to this policy are listed in the coding section below.

Bundled Services

The following services are not separately payable when billed on the same day as specific E&M services.

- Annual wellness visits are bundled into preventative visits
- Cervical or vaginal cytopathology is bundled into preventive or problem-oriented visits
- Collection of blood from an Implantable venous access device or venous catheter is bundled into problem-oriented visits
- Screening pap smears are bundled into preventative visits
- Screening pelvic/breast/rectal examinations are bundled into preventive and problem-oriented visits
- Interpretation and report of ECG is bundled into problem-oriented, inpatient, or ED visits
- Preventive medicine counseling is bundled into preventative visits
- Removal of impacted earwax is bundled into any E&M visit
- Pulse oximetry is bundled into any E&M visit
- Standby services performed on the same day as E&M.
- Peak expiratory flow rate (S8110) is considered a part of any E/M or physician service codes and will not be eligible for separate reimbursement unless shown to be a distinct and separately identifiable service.
- Any cardiovascular service billed on the same day as an E&M service will not be eligible for reimbursement unless shown to be significant and separately identifiable.

E&M Services During Global Periods

E&M services are not separately payable when provided on the same day (or the day prior, for major surgical procedures) as a procedure with a global period, as defined by the CMS or Oscar (for codes with global surgery indicator YYY). Exceptions to this policy are for significant and separately identifiable services, when billed with modifier 25, or for services resulting in a decision to perform a major surgery, when billed with modifier 57. For services billed with modifier 25, the lesser of the procedure or E&M rate is paid at 50% of the contracted rate. Oscar may verify whether services are related or truly separate and significant. Review criteria includes, but is not limited to, diagnoses, claim history, and medical records.

E&M services provided within the global period are not considered separately payable unless unrelated to the original procedure and billed with modifier 24.

Emergency Department (ED) Facility E&M Coding

Facilities are entitled to submit CPT E&M codes on a UB form in addition to the E&M's submitted by the ED physician. Facility resource consumption drives the eligible E&M level submitted whereas physician resources drive the physician ED E&M level as outlined by CPT. An applied algorithm that accounts for diagnoses submitted as well as facility services ordered and performed determines the likely appropriate level of the facility E&M reimbursement. Given the inherent variability and complexity relating to the higher level E&M codes (99283, 99284, or 99285) the algorithm will verify whether the higher level codes are accurately reflecting the complexity of the visit and if not, the ED E&M reimbursement will reflect the algorithm output. Since the focus is on purely the level 3,4 and 5 codes, coding recommendations will only focus on a reduction in code levels. This will result in:

1. Fair and appropriate facility reimbursement for ED services rendered
2. Reduction in facility up coding and corresponding overpayment

CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles applicable to emergency department services provide that facility coding guidelines should: follow the intent

of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code; be based on hospital facility resources and not based on physician resources; and not facilitate upcoding or gaming.

Initial/Subsequent E&M Codes

Consistent with CMS and CPT® guidance, initial observation/inpatient care codes and codes that include the initial observation/inpatient care are only reimbursable on the first day of treatment and are not intended to be billed on subsequent days of the observation/inpatient stay.. Likewise, subsequent observation/inpatient care codes will be reimbursable on each additional day of the observation/inpatient stay.

Consultation Codes

In accordance with CMS, Oscar will no longer separately reimburse for office/outpatient consultation codes (CPT ® codes 99242–99245) and inpatient/observation consultation codes (CPT® codes 99252–99255). Consultation services should be reported with an appropriate office/outpatient or inpatient/observation E&M code representing the location where the visit occurred and the level of complexity of the visit performed, such as code ranges 99221-99223, 99304-99306, and 99202-99215.

Interprofessional telephone/internet consultation services are provided by a consulting physician at the request of the patient's primary or treating physician to assist in the diagnosis and/or management of the patient's problem without a face-to-face encounter with the consultant. 99446, 99447, 99448, 99449, 99451, 99452 are considered incidental and not eligible for separate reimbursement.

Care Management Services

Care Management Services which include complex chronic care management (99487, 99489), chronic care management (99439, 99490, 99491, G0506), transitional care management (99495, 99496), advanced care planning (99497, 99498) are not separately reimbursable.

Critical Care Services

Evaluation and Management services (99202-99205, 99211-99215, 99221-99223, 99231-99233, 99281-99285, 99381-99387, 99391-99397, G0402) performed in the same location as critical care services (99291-99292) on the same DOS will be denied unless modifier -25 guidelines are followed.

Critical care service procedures will be denied as incidental when submitted with Neonatal and Pediatric Critical Care services (99466, 99467, 99468, 99469, 99471, 99472, 99475, 99476). The critical care service procedures are included in the pediatric and neonatal critical care codes.

Critical Care services include the following services: 36000, 36410, 36415, 36591, 36600, 43752, 43753, 71045, 71046, 92953, 93598, 94002-94004, 94660, 94662, 94760, 94761, 94762 and are not separately payable on a professional claim.

Hospital Mandated On Call Service

Hospital mandated on call service; in hospital, each hour (99026) and hospital mandated on call service; out of hospital, each hour (99027) will be considered incidental to Evaluation and Management services and not separately payable.

Hospital Discharge Day

Only one hospital discharge day management service (CPT® 99238-99239) will be reimbursed 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.

Electromyographic (EMG) test, nerve conduction study (NCS)

Consistent with guidance from the American Association of Neuromuscular and Electrodiagnostic Medicine, Electromyographic (EMG) test, nerve conduction study (NCS), blink reflex test, or neuromuscular junction (NMJ) testing should not be billed on the same day as

E&M services according to expert panel guidance. Therefore, E&M services will not be eligible for reimbursement unless shown to be distinct and separately identifiable.

Billing and Coding

Codes included in this section do not guarantee coverage or reimbursement. Applicable codes are for reference only and may not be all inclusive.

Code	Description
99381-99387,99391-99397, G0402	Preventive E&M Services
99202-99205,99211-99215	Problem-Oriented E&M Services
99281-99285	Emergency Department E&M Services
99221-99223,99231-99233	Observation or Inpatient E&M Services
99360	Standby Services
G0438, G0439	Annual Wellness Visits
88141-88155, 88164-88167, 88174-88175	Cervical or Vaginal Cytopathology
36591, 36592	Collection of Blood from an Implantable Venous Access Device or Venous Catheter
Q0091	Screening Pap Smear
G0101	Screening Pelvic and Clinical Breast Examination
G0102	Screening Rectal Exam
93010, 93042	Interpretation and Report of ECG
93018	Interpretation and Report of Cardiovascular Stress Test
71045, 71046	Chest X-Ray (1 and 2 views)
99401-99404, 99411, 99412	Preventive Medicine Counseling
69209, 69210	Removal of Impacted Earwax
94760-94672	Pulse Oximetry
99172, 99173, 99408, 99409, G0396, G0397, G0442, G0444	Screening Services
99406, 99407, 99411, 99412, G0245, G0246, G0296, G0443, G0445-G0447, G0473, H0005, S0257, S0265, T1006, T1027	Counseling Services
G0270, G0271, S9470	Nutrition Therapy Services
99358, 99359	Prolonged Services provided by a Physician in Outpatient Setting
99242-99245, 99252-99255, 99281-99285, G0245,	E&M Services overlapping with Preventative Services

G0246, S0285	
99242-99245	Outpatient Consultation E&M Services
99252-99255	Inpatient Consultation E&M Services
99495, 99496	Transitional Care Management
99497, 99498	Advance Care Planning
99415, 99416	Prolonged Services provided by Clinical Staff
99418	Prolonged Services provided in Inpatient Setting
99439, 99490, 99491, G0506	Chronic Care Management
99487, 99489	Complex Chronic Care Management
99468-99472, 99477, 99480	Neonatal Intensive Care Services
99475-99476	Pediatric Intensive Care Services

Frequently Asked Questions

- Are facilities required to bill the same CPT code as the physician for an ED visit encounter?
    - No. While the intent of the CPT visit code should be followed by both facility and physician, facility resource utilization may cause the facility E&M level to be appropriately higher or lower than the physician level.
- What should facilities do to ensure fair and appropriate reimbursement on submitted ED E&M codes?
    - UB Claims for services rendered in an emergency department should include all diagnosis and procedure codes relevant to the emergency department visit and be billed at the appropriate E&M level.
- Are submitted facility E&M codes recoded by the payer to the level designated by the algorithm?
    - No. The E&M code submitted by the facility is accepted as is. Payment, however, is based on the E&M level aligned with resource utilization as determined by the applied algorithm.
- Is the algorithm applied to facility E&M codes submitted for those admitted to the inpatient facility from the ED?
    - No. The algorithm is only applied to patients who are discharged from the ED.
- Are facility ED critical care codes subject to the algorithm that determines the level of ED resource utilization?
    - No. Critical care CPT codes submitted for services rendered to patients who are discharged from the ED are not subject to the algorithm methodology.
- Does this methodology apply to all ED's or only select ED's determined by the payer?
    - The methodology applies to all participating and non-participating ED's who treat eligible members.
- Does the application of the algorithm only result in lower facility payments for submitted ED E&M CPT codes?
    - Yes. Since the algorithm is focusing on resource utilization relating to the highest level E&M codes (99283, 99284, 99285), the resulting payment level may be the same or less than the allowed amount for the submitted facility ED E&M code.

Related Policies

1. **Bundled Services**
2. **Obstetrical Care Bundling**
3. **Services Delivered via Telemedicine**
4. **Modifier Guidelines**

References

1. CMS Internet Only Manuals, Medicare Claims Processing Manual, Ch. 13, Section 100.1 (X-Rays and EKGs Furnished to Emergency Room Patients).
2. CMS Internet Only Manuals, Medicare Benefit Policy Manual Ch. 15, Section 30.B (Consultation Codes).
3. CMS Medicare Claims Processing Manual (Ch. 12, Section 30.6.18 Split/Shared E&M visit)

Publication History

Date	Action/Description
4/02/2017	Original Documentation
4/20/2017	Approval and inclusion in Oscar Provider Manual
7/20/2017	Policy Updated
8/29/2018	Policy Updated
4/09/2019	Policy Updated
3/26/2020	Policy Updated
06/25/2024	Annual Review; Description section added; Added New Patient Frequency Parameters, Added Annual Wellness limits based on definition, Deleted Statement about Cardiovascular Stress Test, Added FS modifier requirement for split/shared visits, Deleted Statement that I&R of CXI being bundled into ED visit, Added Standby Services as bundled, Added Peak Expiratory Services as bundled, Added statement that cardiovascular services bundled in E&M unless modifier appended, Added Initial and Subsequent chronological filing requirement, Updated Consult codes as no longer payable, but to be resubmitted with appropriate E&M code, Adde Interprofessional telephone/internet consult statement, Rephrased Care Management Code verbiage to align with updated coding, Added Critical Care services coding requirements, Added Hospital Mandated on Call services, Added Hospital Discharge Day information, Added EMG test statement, Updated coding section to align with updated codes.
03/27/2025	Off-cycle verbiage update to Screening/Counseling/Nutrition Therapy/Prolonged Services/Overlapping E&M Services section of policy.