Evaluation and Management

Policy

Harvard Pilgrim reimburses contracted providers for the provision of evaluation and management (E&M) services.

Policy Definition

Evaluation and Management (E&M) — Harvard Pilgrim follows the CMS 1995/1997 and AMA 2021 documentation guidelines for E&M services. Medical records must support reported levels of service based on these guidelines. Medical records may be requested for review to ensure appropriate documentation of services rendered and accuracy of coding. Refer to the most current version of the American Medical Association's (AMA) CPT-4 manual for the complete descriptors for E&M services and instructions for selecting a level of service.

Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply. Refer to *Referral, Notification and Authorization* for more information.

HMO/POS/PPO

A referral is required for specialist services (including E&M services), for HMO and in-network POS members.

Open Access HMO and POS

For *Open Access HMO and Open Access POS* products, no referral is required to see a contracted specialist.

Harvard Pilgrim Reimburses[1]

HMO/POS/PPO

Multiple E&M Services — Same Day

When multiple providers within the same billing group (using the same federal tax identification number) perform evaluation and management (E&M) services on the same patient, on the same day, Harvard Pilgrim will reimburse only the E&M service with the highest allowable amount.

Only one E&M service (outpatient or inpatient) will be reimbursed per date of service when providers using the same federal tax identification number and of the same specialty/subspecialty, regardless of whether the visits are related or not.

- Example: A member is seen in the hospital by internal medicine physician with a subspecialty of gastroenterology for hypovolemia and is also seen for septicemia by another internal medicine physician with a subspecialty of infectious disease within the same group.

Preventive Visit and Problem-Oriented Visit ---Same Day

Harvard Pilgrim will reimburse a preventive visit and a problem-oriented visit when the 25 modifier is applied to the problem-oriented visit. Reimbursement for the higher valued service will be made at 100% of the contracted allowable rate, and reimbursement for the lower valued service will be made at 50% of the contracted allowable rate.

Addressing a problem or abnormality during a preventive visit is considered part of the preventive visit, a problem-oriented visit should only be reported when there is a significant problem or abnormality addressed and there is additional work required to perform the key components of a problem-oriented E&M service. The medical record documentation must support both services.

- If both the preventative and problem-oriented visit is provided to a new patient (as defined by CPT), bill the preventive service with the age appropriate “new patient” CPT code, and the problem-oriented visit as “established patient.”

Significant, Separately, Identifiable E&M with Global Day Service — Same Day

Policy applies to all professional services performed in an office place of service - when significant, separately identifiable E/M service (appended with 25 modifier) and any service that has a global period indicator as designated by CMS of 0, 10, 90 or YYY is performed on the same day, the E&M service will be reimbursed at 50% of the contracted allowable. When the E&M RVU value is greater than the procedure, the reduction will be applied to the global procedure code.

New Patient Visits

New patient visits are reimbursed when the physician/qualified health care professional, or another physician of the same specialty within the same group, has not seen the patient for three years.

Certification of Home Health Services

Physician certification and recertification of home health services are reimbursed for Medicare covered services provided by a home health agency.

Genetic Counseling (when medically necessary)

Genetic counseling requires a referral from the member’s PCP. The PCP should always refer the member to a Harvard Pilgrim–contracted provider for services.

Emergency Department Care

E&M services rendered at a hospital for unscheduled episodic care to patients who present for immediate medical attention. (The facility must be open 24 hours a day.)

Critical Care

Critical care services are reimbursed in accordance with, but not limited to, the CPT definition.

- Consistent with the total duration of time the physician spends providing his/her full attention to a critically ill or injured patient and the work directly related to the patient’s care.

Services rendered to a non-critical patient located in a critical care unit will be reimbursed using the appropriate E&M code.

Pediatric and Neonatal Intensive Care

Pediatric and neonatal intensive care services are reimbursed in accordance with CPT definition.

Patient Transport

Attendance and direct face-to-face care by a physician during an inter-facility transport of a critically ill or critically injured child, if the total time is greater than 30 minutes.

Nursing Facility Services

Nursing home E&M visits inclusive of services related to the admission and other related services when provided by the same physician (e.g., emergency room, doctor’s office).

Physician Home Visit

Harvard Pilgrim reimburses physician home visits.

Services Rendered on Sunday and Holidays

CPT code 99050 will only be reimbursed when provided in addition to basic services, on Sundays and the following holidays; New Year's Day, President’s Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Thanksgiving Day, and Christmas Day.

Telemedicine Services

Telemedicine is the use of interactive audio, interactive video or interactive data communication in the delivery of medical advice, diagnosis, and care or treatment. Telemedicine does not typically include the use of facsimile or audio-only telephone.

Collaborative Care

Collaborative care services are reimbursed when provided under the direction of a treating physician or other qualified health care professional that identifies a member's behavioral health needs and integrates care management support and regular psychiatric inter-specialty consultation with the primary care team during a calendar month. When billing collaborative care services delivered during the calendar month use the last date that the collaborative care service was performed in the month as the DOS on the claim form. Claims must be submitted after the services have been rendered in the entire month.

99492: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

99493: Follow up psychiatric collaborative care management, first 60 minutes in a following month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional directs. (use 99494 in conjunction with 99492,99493)

G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

Harvard Pilgrim Does *Not* Reimburse

HMO/POS/PPO

- Adjunct codes reported in addition to basic services CPT codes 99051-99060.
- After-hours services provided in the office during regularly scheduled evening, weekend, or holiday office hours.
- Airway inhalation treatment when billed with inpatient E&M codes.
- Analysis of data stored in a computer.
- A non-direct patient service or a service where the patient is not present.
- Consultation services
- CPT 99211, with or without a modifier 25 when billed on the same day as a chemotherapy administration service, a non-chemotherapy drug infusion or a drug injection service.
- Electronic visits (e-visits).
- E&M services on the same day as a surgical procedure unless it is a significant and separately identifiable service, *or* it is above and beyond the usual preoperative and postoperative care associated with the procedure and the correct modifier is appended.
- Generic supplies (A specific HCPCS code must be submitted for reimbursement consideration.)
- Handling fees, device handling, or telephone E&M services.
- Hospital-mandated on call service, in hospital or out of hospital.
- Medical conferences by a physician with an interdisciplinary team of health professionals to coordinate care of a patient when the patient is not present.
- Medical and surgical supplies and/or items, such as, but not limited to, syringes, needles, local anesthetic, saline irrigation, dressings or gloves when billed in the office location.
- Medical testimony.

- Physician standby services.
- Pre-operative surgery clearance if the same PCP has been reimbursed for an E&M visit to his/her own patient for the same or related condition or diagnosis.
- Prolonged service. (This may be reimbursed only after individual consideration which is based on the medical documentation).
- Provider travel time and/or expenses.
- Venipuncture charges (collection of blood) made in conjunction with blood or related laboratory services or evaluation and management service when reported on the same day by any provider reporting the same Federal Tax ID Number (TIN).
- Services defined by CPT as included in the definition of patient transport codes.
- Telephone or Online digital E&M services submitted by the same provider group on the same date of service as an office visit/evaluation and management service.

Member Cost-Sharing

Services subject to applicable member out-of-pocket cost (e.g., co-payment, coinsurance, deductible).

Provider Billing Guidelines and Documentation

Coding[2]

Code	Description	Comments
36405, 36406, 36410, 36415, 36416, 36420, 36591, 36592	Venipuncture	Not reimbursed separately when billed with blood or related laboratory services or with E&M services
36620	Insertion of an arterial catheter	Separately reimbursed when billed with an emergency department E&M code
94640	Airway inhalation treatment	Not reimbursed when billed with an inpatient E&M service
99000, 99001	Handling fees	Not reimbursed
99002	Device handling	
99026, 99027	Hospital-mandated on-call service, in or out of hospital	
99050	After-hours services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday) in addition to basic service	Reimbursed when provided in addition to basic services, on Sundays and the following holidays; New Years Day, President's Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Thanksgiving Day, and Christmas Day.
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	Not reimbursed
99053	Services provided between 10 p.m. and 8 a.m. at a 24-hour facility in addition to basic service	
99056	Services typically provided in the office, provided out of the office at the request of the patient, in addition to basic service	
99058, 99060	Office services provided on an emergency basis in or out of the office which disrupts other scheduled office services, in addition to basic service	

Code	Description	Comments
99070	Materials charges; generic supplies	Not reimbursed; a specific HCPCS code is required for reimbursement consideration
99075	Medical testimony	Not reimbursed
99080	Special reports	
99082	Unusual travel	
99173	Screening for visual acuity	Not reimbursed with E&M
99242-99245 or 99252–99255	Consultation E&M service codes	Not reimbursed
99281–99285	Emergency department services	Bill for unscheduled episodic emergency medical care performed in an emergency department
99288	Physician direction of emergency medical systems (EMS) emergency care, advanced life support (ALS)	Not reimbursed
99291, 99292	Critical care	Bill initial critical services (first 30–74 minutes) on one line with a count of one; bill each additional 30 minutes segment on one line with the applicable count
99358, 99359	Prolonged services (no direct patient contact)	Not reimbursed
99360	Physician standby services	Not reimbursed
99366–99368	Team conference with and without patient by physician or non-physician	Not reimbursed
99401–99404, 99411–99412	Preventive medicine counseling (separate procedure)	Not separately reimbursed when billed with a preventive exam or a problem-oriented E/M visit.
99415	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour	Not reimbursed
99416	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes	Not reimbursed
99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time	Not reimbursed; may be appealed for reimbursement after individual consideration of medical record documentation

Code	Description	Comments
99418	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service	Not reimbursed; may be appealed for reimbursement after individual consideration of medical record documentation
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Not reimbursed
99466, 99467	Critical care services delivered by a physician during an interfacility transport of a critically ill or injured patient 24 months or less	Use 99467 in conjunction with 99466
99468, 99469	Initial subsequent inpatient neonatal critical care	Bill for critically ill neonates age 28 days or less
99471, 99472	Initial subsequent inpatient pediatric critical care	Bill for critically ill infants 29 days through 24 months of age
99475, 99476	Initial subsequent inpatient pediatric critical care	Bill for critically ill children 2 through 5 years of age
99478-99480	Subsequent intensive care per day for the recovering very low birth weight infant	Bill with appropriate code by infant weight
99487, 99489	Complex chronic care coordination services	Reimbursed for facility only
99490	Chronic care management services, at least 20 mins of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Not reimbursed
99497, 99498	Advance care for planning	Reimbursed
A4649	Surgical supply miscellaneous	Not reimbursed; a specific HCPC code is required for reimbursement consideration
G0102	Prostate cancer screening; digital rectal examination	Not separately reimbursed when billed with an E&M service or when billed by a facility
G0372	Physician services required to establish and document the need for a power mobility device (PMD)	Not reimbursed

Code	Description	Comments
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	Not reimbursed; may be appealed for reimbursement after individual consideration of medical record documentation which must reflect the total time spent with the patient
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes)	Not reimbursed; may be appealed for reimbursement after individual consideration of medical record documentation

Other Information

When the patient's condition requires a significant, separately identifiable E&M service modifier 25 should be appended/reported. The E&M service must be above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure performed.

For E&M services that are unrelated to the original procedure during the postoperative period modifier 24 should be appended/reported.

Modifiers should only be appended/reported when the medical record documentation clearly supports the use of the modifier.

For time-based services, including prolonged services, medical record documentation must include total time. This includes face-to-face time and non-face-to-face time. If there is face-to-face time and non-face-to-face time that occurs several times during the same date of service for the same member, total time needs to be clearly documented.

Related Policies

Payment Policies

- Anesthesia
- CPT & HCPCS Level II Modifiers
- Home Health Care
- Hospital-based Clinic
- Surgery
- Telemedicine/Telehealth

Clinical/Authorization Policies

- Home Health Care
- Genetic and Molecular Diagnostic Testing Prior Authorization

PUBLICATION HISTORY

06/01/01	original documentation
10/01/01	added PCP may bill consultations
01/01/02	added patient transport reimbursement
04/01/03	2003 coding update; pediatric reimbursement clarification; after hours clarification; added separate reimbursement for insertion of an arterial catheter in the ER; added airway treatment with inpatient E&M not separately reimbursed
01/01/04	clarified “does not reimburse” vs. “does not separately reimburse;” starred surgical procedures removed
10/31/04	added CPT codes and definition section; routine blood draws not separately reimbursed
01/31/06	annual review and coding update; clarified reimbursement and billing for a preventive E&M billed with a problem-oriented E&M end the modifier 25
08/01/06	effective10/01/06, HPHC will be reimbursing PCP’s for outpatient consultation visit to his/her own patients for pre-operative surgery clearance only submitted with primary diagnosis code V72.81–V72.84
10/31/06	annual review, further clarification of new patient well and sick E&M services, and E&M services on the same day as a surgical procedure
01/31/07	coding update, well and sick reimbursement information added
10/31/07	annual review; added under HP reimburses simple telephone E&M services as of 01/01/08 for members with specific behavioral health diagnoses, added modifier 25 information
01/31/08	annual coding update
10/31/08	annual review, minor edits for clarity, update to billing guideline and documentation
01/31/09	annual coding update
02/15/09	effective 04/01/09, CPT code 99050 reimbursed on Sundays and holidays only
10/15/09	annual review; added telemedicine services for NH and ME under reimbursement section, and does not reimburse section
01/15/10	clarification of multiple E&M same day and providers reporting the same TIN
10/15/10	annual review; policy update—same day significant, separately identifiable E&M service with surgery/diagnostic procedure
04/15/11	clarification of same day- significant, separately identifiable E/M service with global day service
08/15/11	annual review; minor edits
01/01/12	removed First Seniority Freedom information from header
09/15/12	annual review; updated 99050 to include Columbus Day holiday
01/15/13	annual coding update; E&M and global px policy update; added clarification to E&M service with global day service, same day
10/15/13	annual review; updated telemedicine
01/15/14	annual coding update; added new codes 99446-99449, effective 01/01/14; narrative correction for code definition 99444
06/15/14	added *Connecticut Open Access HMO* referral information to Prerequisites
10/15/14	annual review; added telemedicine definition
01/05/15	annual coding update
07/15/15	added effective dos 10/01/15, CPT 99211 will no longer be reimbursed with chemotherapy administration, non-chemotherapy drug infusion, and/or drug injection services; added to coding grid, preventive medicine counseling will no longer be reimbursed when billed with preventive or problem oriented E/M visit; ICD-10 coding update
10/15/15	annual review; administrative edits
01/15/16	annual coding update
06/15/16	added GT modifier billing information to telemedicine services
07/15/16	updated 99497 and 99498 reimbursed as of dates of service 01/01/16
10/15/16	annual review; clarified 99050 is only reimbursed for Sundays and holidays; administrative edits
01/15/17	annual coding update
02/15/17	removed moderate sedation, added Anesthesia as a related payment policy
04/15/17	added to Harvard Pilgrim Will Not Reimburse CPT 99241-99245 as of dos 06/15/17 if the same provider has billed any E/M service in the previous 12 months
10/15/17	annual review; no changes
11/15/17	updated multiple E&M services as of dates of service 12/15/17 will be reimbursed when providers have different specialties; administrative edits for clarity, added Telemedicine/Telehealth Payment Policy as related policy
02/01/18	annual coding update; updated Open Access Product referral information under Prerequisites
11/01/18	annual review; removed references to ICD-9
02/01/19	annual coding update
05/01/19	added Hospital-based Clinic as related policy
10/01/19	annual review; added office supplies will not be reimbursed; added Home Health Care Payment Policy to Related Policies section; added Home Health Care Medical Review Criteria Policy and Molecular Diagnostic Management Medical Review Criteria Policy to Related Policies section; added office supplies will not be reimbursed
02/03/20	annual coding update
08/03/20	added codes as venipuncture in coding grid, not reimbursed when reported by same TIN
11/02/20	annual review; administrative edits; removed codes associated with telemedicine and telemedicine E&M services
02/01/21	annual coding update; updated policy definition, revised language when addressing a problem or abnormality during a preventive visit, administrative changes to HP does not reimburse, updated “other information”

03/01/21	added G0102 not reimbursed when billed by a facility as of date of service 5/1/2021
04/01/21	added requirements for time-based coding, removed reference to total time for prolonged codes
04/09/21	updated information on time documentation
09/01/21	added consultation services as of dates of service on or after November 1, 2021 will no longer be reimbursed
11/01/21	annual review; no changes
11/01/22	annual review; removed CPT 99421-99423
02/01/23	annual code update
11/01/23	annual review; administrative edits
08/01/24	added collaborative care definition and procedure codes

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

[2]The table may not include all provider claim codes related to E&M services.