moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM076
Policy Title:	2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services		
Section:	Evaluation & Management Services	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☐ All dates ☒ Specific date(s): ☒ Date of Service; For Facilities: ☒ Date of E/M service ☐ Date of processing For OV & OP services: January 1, 2021 and following. For all other E/M services: January 1, 2023 and following.
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2021	Initially Published:	12/30/2020
Last Updated:	4/4/2024	Last Reviewed:	4/10/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		4/10/2024	

Reimbursement Guidelines

A. General Statement

The 2021 revisions to the Evaluation and Management (E/M) codes made changes to the code definitions, code selection process, and to the prolonged services guidelines. The 2023 E/M revisions expand those changes to all remaining care settings. The changes also impact documentation requirements to support billed E/M procedure code(s).

B. History and Physical Examination.

1. The extent of the history and physical examination is no longer used in selecting the E/M level and procedure code; as a result, the code descriptions no longer include references to these aspects of the visit.
2. Yet a medically appropriate history and physical examination is still expected to be performed with every evaluation and management service.
    a. The history and the physical examination is important to document for clinical communication with other current and future medical professionals.

b. However, the documentation of the history and the physical examination is no longer scrutinized and quantified for purposes of selecting the E/M level and billing procedure code.

3. Reimbursement for the work of the history and physical exam is included in reimbursement for the E/M procedure code.

C. Levels of E/M Services.

1. Within each category or subcategory of E/M service there are three to five (usually four) levels of E/M services to report. In some categories the lowest level visit codes have been deleted because the Medical Decision Making (MDM) was the same as for the next code (which is retained).

2. "Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient." (AMA[22])

3. When the practitioner's scope of license includes evaluation and management services, each and any level of E/M services may be used by all physicians or other qualified health care professionals. (AMA[22])

D. Selecting the Appropriate Level of E/M Service.

1. For all categories other than the Emergency Department, the appropriate level of E/M services may be selected based on the provider's choice of either of the following (note: exception for psychotherapy with E/M):

   a. The level of MDM, as defined for each service.

   b. The total time for E/M services performed on the date of the encounter. When using Time:

      i. The level of medical decision-making is not considered.

      ii. Total time on the date of the encounter is used.

         1) Total time includes both face-to-face and non-face-to-face time, as long as it is personally spent by the physician or other qualified health care professional.

         2) Time spent on the previous date or any date following the encounter (e.g., after midnight) is not included in the Total Time.

         3) Time spent by clinical staff is not included.

2. Exception to rule # 1 above:
   Time may not be used to select E/M code when psychotherapy services are performed with E/M services; the E/M service must be coded based upon medical decision making. (AMA[38, 39])

   a. The psychotherapy services are reported with specific time-based procedure codes (90833, 90836, 90838) which are add-on codes to the E/M service procedure code.

      i. The separate time for the psychotherapy needs to be documented

      ii. The time spent performing the E/M service cannot be counted in the time for the psychotherapy service. Thus, the time documented for the psychotherapy services must be less than the total amount of time spent with the patient.

b. Prolonged services may not be reported. (AMA[38])

3. The AMA has provided detailed instructions in the E/M guidelines for both methods (MDM and Time) of determining the E/M level.
   a. Tables are included.
   b. Some specific examples are included.
   c. Further information and details, additional criteria for Data Reviewed and examples of Risk of Complications/Morbidity/Mortality are available from the AMA. (AMA[3], AMA[4], AMA[11])

4. The medical record documentation must support the criteria for whichever method of level selection is used.
   a. Medical records do not need to be sent with the claims for E/M codes. Should Moda need to request medical records, be sure they are returned to Moda within 30 days from the date of our request.
   b. When medical records are reviewed, Moda Health will accept documentation of the following to support the billed level of service:
      i. The level of the medical decision making (MDM) for each service;

         Medical decision making is documented by the complexity of establishing the diagnosis and/or management options that are measured by:

         1) The number of possible diagnosis and/or number of management options to be considered;
         2) The amount and/or complexity of medical records, diagnostic tests, notes, reports or other information that must be obtained and reviewed and analyzed;
         3) The risk of significant complications, morbidity and/or mortality, as well as comorbidities that are associated with the member's presenting problems, diagnostic procedures and/or possible management options.

      - OR -

      ii. The total time for E/M services performed on the date of the encounter.

         1) Document time with begin-time and end-time.
         2) If E/M service time is not continuous then multiple begin-time and end-times with type of activity may need to be documented in the medical record.
         3) Refer to the CPT guidelines and various CPT Assistant articles for the various activities that qualify and don't qualify for calculating the total time on the day of the encounter. (AMA[2])

5. Additional resources are available from the AMA, CMS, and the local Medicare Administrative Contractor (MAC):
   a. Webinar on 2023 E/M Changes. (AMA[24])
   b. Multiple videos, tools, FAQs, and a Simplified Outpatient Documentation & Coding Toolkit are available at the AMA's page on "Implementing CPT® Evaluation and Management (E/M) revisions." (AMA[28])

c. Published CPT Assistant articles. (AMA[1, 2, 3, 4, 5, 6, 7, 8, 9, 21, 26, 27])

d. Additional articles & documents on the AMA website. (AMA[10, 11, 12, 22, 23, 24, 28])

e. "Medicare Physician Fee Schedule Final Rule Summary: CY 2023." MLN Matters Number: MM12982. (CMS[33])

f. Noridian Medicare webinar on "2023 Evaluation and Management Updates," offered on December 8, 2022, December 21, 2022, January 10, 2023, and January 26, 2023.

(Noridian indicated the December 8, 2022 session was being recorded; as of this update a link is not found but it may later be posted on-demand listening.)

E. Prolonged Services Changes and Code Sets.

1. Prolonged services can now only be billed in combination with the highest level of E/M in each category (setting grouping).

   This is because prolonged services is a time-based service, and the level of E/M service/procedure code can now be selected based upon Time. Extended time (prolonged service) can only be billed in addition to the procedure code for the maximum amount of time.

2. The list of acceptable primary procedure codes for 99417 have changed with the 2023 revisions. These guidelines are listed within parentheses directly below the code description.

   a. Four procedure codes have been added as acceptable primary procedure codes.

   b. Three procedure codes have been removed from the list of acceptable primary procedure codes and added to a second parenthetical list of codes which may not be reported on the same day as 99417.

3. Neither 99417 nor 99418 may be reported with psychotherapy procedure codes; no prolonged services procedure code is available for this situation.

   a. Dr. Peter Hollmann, Co-Chair of the CPT/RUC Workgroup on E/M, explained the psychotherapy participants in the E/M Revision workgroup indicated a prolonged service code is not needed for psychotherapy services. (Hollman[25])

   b. Should providers disagree with this decision, they will need to work directly with their professional specialty society/association to have a request submitted to the AMA for a new procedure code to be created for this purpose.

4. Two separate and competing sets of prolonged services procedure codes to use (AMA & CMS).

   a. The AMA and CMS have each created different/separate prolonged services procedure codes and guidelines.

      i. The code descriptions for the AMA code 99417 and 99418 and the corresponding CMS codes G2212, G0316, G0317, and G0318 are very similar, but with subtle differences.

      ii. The guidelines for time required to report these codes also have subtle differences.

b. Reason:

i. The RVU for each E/M procedure code includes approximately 15 minutes of additional provider time beyond the time specified in each E/M code description.

1) Yet the AMA prolonged services codes may be reported for the first full 15 minutes beyond the time specified in the E/M code descriptions.

2) Because of this, CMS indicates that if the AMA prolonged services procedure codes and guidelines are used, the first 15 minutes of prolonged services will be paid twice, once under the primary E/M procedure code, and a second time under the first unit of the prolonged services procedure code.

ii. CMS also strongly prefers prolonged services codes for specific care settings to enable better data collection from claims procedure codes alone.

iii. CMS has outlined additional concerns related to the AMA prolonged services codes and guidelines. (CMS[30, 31])

c. Due to the above reasons, CMS will not accept the AMA prolonged services codes and considers them invalid for Medicare. Instead, CMS created G2212, G0316, G0317, and G0318 for prolonged services with specific guidelines.

F. Prolonged Services Reimbursement & Processing.

Because our fee schedules use CMS fee schedule methodology, including RVUs and the double-payment concerns noted above, we will process prolonged services as follows:

1. Commercial and Medicare Advantage plans:

a. CPT codes 99417 and 99418 are not accepted for processing for Commercial or Medicare Advantage plans. Instead, use G2212, G0316, G0317, and G0318 .

b. CPT codes 99417 and 99418 will be denied with one of the following:

Denial explanation code:

53B	This procedure code is not accepted for processing by Moda Health for this type of plan and/or line of business.
u14	This procedure code is not accepted for processing for this type of plan and/or line of business.

835 CARC/RARC denial combination:

CARC 16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
RARC N657	This should be billed with the appropriate code for these services.

2. Medicaid plans:

    a. 2021 E/M changes:

        i. Procedure code G2212 was initially not listed on the OHA fee schedule and so 99417 was accepted for prolonged E/M services.

        ii. G2212 was later added to the OHA fee schedule and became the Medicaid procedure code for prolonged office visit or outpatient E/M services.

    b. 2023 E/M changes:

        i. CPT codes 99417 & 99418 will be accepted for prolonged services until such time as the OHA fee schedule lists fees for G0316, G0317, and G0318 and they are included for OHA coverage on the prioritized list or under ancillary coverage provisions.

        ii. If no OHA fee is listed for 99418, then the CMS RVUs for G0316, G0317, and/or G0318 will be used to follow the DMAP MPA calculations to establish an allowance for 99418.

G. Determining Specialty For Non-Physician Practitioners (NPP).

1. The CMS and CPT guidelines differ for determining specialty for non-physician practitioners (NPP).

    a. CMS: "…classifies NPPs in a specialty that is not the same as a physician with whom the NPP is working…" (CMS[18])

    b. AMA/CPT: "When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician." (AMA[19])

2. We follow the AMA/CPT guidelines for NPP specialty determination.

    Thus, when advanced practice nurses and physician assistants are working with a group of physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physicians with which they work. This may impact clinical editing based on same-specialty.

H. Shared or split visits.

1. A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) (e.g., PA, NP, CNS, etc.) jointly provide the face-to-face and non-face-to-face work related to the visit.

    a. Per CMS, "Split (or shared) visits are furnished only in the facility setting…" (CMS[17])

    b. Only one of the providers may submit a claim for the joint split/shared visit.

    c. The claim for the visit is submitted by the provider who performed the substantive portion of the visit.

2. When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other

qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time.

a. Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted). (AMA[11])

b. Examples:

i. The PA sees an established patient in the exam room for 20 minutes, then the MD joints the PA in the exam room and they both see the patient together for 12 additional minutes. This visit is being coded based upon time rather than MDM.

This is a 32-minute visit (99214). The 12 minutes when both the PA and the MD were in the room with the patient can only be counted once, not once per each provider present in the room.

ii. The NP sees an established patient in the exam room for 25 minutes, then the NP leaves to discuss the patient with the MD for 5 minutes. Then the MD sees the patient for an additional 20 minutes. At the end of office hours, the MD and the NP meet for another 15 minutes to discuss the case and jointly develop the long-term treatment plan. This visit is being coded based upon time rather than MDM.

This is a 65-minute visit (99215). The 5 minutes spent discussing the patient between the switch from NP to MD and the 15 minutes of joint care and treatment planning at the end of the workday can only be counted once. This time cannot be counted as 20 minutes for the NP and also 20 minutes for the MD (that would be considered double-counting or double-dipping).

3. Requirements for CPT code 99211

a. The code definition for 99211 describes a visit for "…an established patient, that may not require the presence of a physician or other qualified health care professional..." and does not have a time frame defined.

b. CPT 99211 does not require a face-to-face encounter with the physician or other qualified health care professional (QHP).

i. The face-to-face service may be provided by clinical staff.

ii. The physician or other QHP who bills CPT 99211 must spend time supervising the clinical staff in order to report 99211. (See "direct supervision" and "immediately available" in the Definition of Terms Table section of this policy.)

I. New Patient Versus Established Patient E/M Codes

1. The amount of time required for billing a new patient visit code is different than the amount of time required for billing an established patient visit code for corresponding level E/M codes. Please reference the time frames listed in the procedure code descriptions.

2. For guidelines regarding whether to select a new patient visit code or an established patient visit code, refer to the following sources:
    a. CPT book guidelines for the date of service in question, Evaluation and Management (E/M) Services Guidelines, New and Established Patient subsection. (AMA[34])
    b. Evaluation and Management Services Guide Booklet (CMS[35])
    c. New Patient vs Established Patient Visit (Noridian[36])
    d. New vs Established Patient Decision Tree Flowchart (Noridian[37])

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AHA	=	American Hospital Association
AMA	=	American Medical Association
APP	=	Advanced Practice Provider
ASO	=	Administrative Services Only
CARC	=	Claim Adjustment Reason Code
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CNS	=	Clinical Nurse Specialist
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
ED	=	Emergency Department (also known as/see also ER)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
EOB	=	Explanation of Benefits
EOP	=	Explanation of Payment (formerly called PDR Payment Disbursement Register)
ER	=	Emergency Room (also known as/see also ED)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MDM	=	Medical Decision Making

Acronym or Abbreviation		Definition
MPFS MPFSD MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
NP	=	Nurse Practitioner
NPP	=	Non-Physician Practitioners
PA	=	Physician Assistant
PDR	=	Payment Disbursement Register (currently called EOP Explanation of Payment)
QHP	=	Qualified Health Care Professional; Qualified Healthcare Professional
RARC	=	Remittance Advice Remark Code
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
TOB	=	Type of Bill
UB	=	Uniform Bill

Definition of Terms

Term	Definition
Advanced practice provider (APP)	'Advanced Practice Provider' is a general title used to describe individuals who have completed the advanced education and training that qualifies them to (1) manage medical problems and (2) prescribe and manage treatments within the scope of their training. Some specific types of APPs include clinical nurse specialists, nurse practitioners, and physician assistants. This term is approximately equivalent to the Medicare term Non-physician practitioner (NPP).
Clinical Staff	A person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but does not individually report that professional service. (AMA[19])

Term	Definition
Direct Supervision	The supervising physician does not need to be present in the room during the procedure but must be immediately available to furnish assistance and direction throughout the procedure's performance. (See also "Immediately Available") In the office setting, the location proximity requires the supervising physician must be present in the office suite. Definition specified at 42 CFR 410.32(b)(3)(ii) (CMS[14], CMS[15], Verhovshek[16])
Drug therapy requiring intensive monitoring for toxicity	The monitoring is performed for assessment of adverse effects from the therapeutic agent that have the potential to cause serious morbidity or death. The monitoring is not performed primarily for assessment of therapeutic efficacy. For further details, reference CPT Assistant. (AMA[4])
External Note(s)	External note(s) are record(s), communication(s), and/or test result(s) from an external physician/other QHPs facility or health care organization. (AMA[4])
General Supervision	The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the [service] and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. Definition specified at 42 Code of Federal (CFR) 410.32(b)(3)(i) (CMS[14], CMS[15])
Immediately Available	The supervising physician must not be performing another procedure that cannot be interrupted and must not be so far away that he or she could not provide timely assistance. (Verhovshek[16])
Independent Historian(s)	An independent historian is an individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to the history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. Key to this definition is that the independent historian should provide additional information, and not merely restate information already provided by the patient. (AMA[4])
Minimal Problem	A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211). (AMA[11])
Morbidity	A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment. (AMA[4])

Term	Definition
Non-physician Practitioner	A Medicare term which Medicare defines as: Health care providers who practice either in collaboration with or under the supervision of a physician, including physician assistants, nurse practitioners, and clinical nurse specialists, are referred to as non-physician practitioners (NPPs). (CMS[20]) This term is approximately equivalent to the non-Medicare term Advanced Practice Provider (APP).
Other Qualified Health Care Professional	An "other qualified health care professional" is an individual who not a physician but is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." (AMA[19]) Other qualified health care professionals consist of Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Midwives, and Certified Registered Nurse Anesthetists (CRNA).
Personal Supervision	The supervision physician must be in attendance in the room during the performance of the service or procedure. Definition specified at 42 CFR 410.32(b)(3)(iii) (CMS[14], CMS[15])
Problem	A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter. (AMA[40])
Problem Addressed	A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay. (AMA[40])
Shared Visit Split Visit	A visit in which a physician and other qualified healthcare professional(s) (e.g. PA, NP, CNS, etc.) jointly provide the face-to-face and non-face-to-face work related to the visit. (AMA[11])

Term	Definition
Social Determinants of Health	Economic and social conditions that influence the health of people and communities. For example, food or housing insecurity. (AMA[4])
Test	Tests are services that result in imaging, laboratory, psychometric, or physiologic data. The differentiation between single and multiple unique tests is defined in accordance with the CPT code set. When a CPT code representing a clinical laboratory panel is reported (eg, CPT code 80047, Basic metabolic panel (Calcium, ionized)), it is considered a single test. (AMA[4])

Procedure codes (CPT & HCPCS):

Code	(*coding tip, reworded from official CPT/HCPCS guidelines) Code Description (**information specific to Moda Health)
99415	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
99416	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)
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 (List separately in addition to the code of the outpatient Evaluation and Management service) ****For Moda Health:** Moda Health does not accept 99417 for processing. Instead, see/use G2212.
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 when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service) *Can only be billed with highest-level E/M if the codes were selected based on the time alone and not medical decision making. Only time of the physician or qualified healthcare professional is counted. (AMA[11], CMS[13]) ****For Moda Health:** Moda Health does not accept 99418 for processing for Commercial and Medicare Advantage plans. Instead, see/use G0316, G0317, or G0318.
G0316	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using 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

Code	(*coding tip, reworded from official CPT/HCPCS guidelines) **Code Description** (**information specific to Moda Health)
G0317	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using 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
G0318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using 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
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)

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Time must be documented in the health record when it is used as the basis for code selection. Third-party payers may have additional criteria regarding the acceptable level of documentation detail required when using time, and they should be contacted to obtain their specific documentation requirements." (AMA[2])

"Data Element Category 2: Independent Interpretation of Tests.

This category addresses the work performed by a physician's independent interpretation of a test that has not been separately reported by another physician or other QHP, who performed the E/M service for the same patient at a different encounter. Key reporting considerations include the following:

- The test should be one for which there is a CPT code and an interpretation or report is customary.
- A form of independent interpretation should be documented by the physician or other QHP but it does not have to conform to the usual standards of a complete report for the test.
- This criterion should not be applied when the physician or other QHP is reporting the service or has previously reported the service for the patient." (AMA[4])

"MDM Element: Risk of Complications and/or Morbidity or Mortality of Patient Management

This element was previously titled "Risk of Complications and/or Morbidity or Mortality." Guideline changes for this element in CPT 2021 E/M increased the emphasis on work performed by the physician or other QHP in addressing patient-management decisions made at the visit that would be associated with the patient's problem(s), the diagnostic procedure(s), and/or treatment(s). It is important to note that this element encompasses the work of both the possible management options selected, as well as those considered but not selected, after sharing the MDM with the patient and/or family. Shared MDM involves

eliciting patient and/or family preferences, patient and/or family education, and explaining the risks and benefits of management options.

An example of shared MDM would be a decision about hospitalization that includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting, or the decision to not hospitalize a patient with advanced dementia with an acute condition, which would generally warrant inpatient care, but for whom the goal is palliative treatment." (AMA[4])

"We are finalizing Medicare-specific coding for prolonged Other E/M services. We are creating three new G codes (one per E/M family) for reporting prolonged hospital inpatient or observation services (G0316), prolonged nursing facility services (G0317), and prolonged home or residence services (G0318). Prolonged cognitive impairment assessment services will be reported using G2212, the Medicare-specific code for prolonged office/outpatient services. CPT codes will not be used to report these services." (CMS[29])

"For 2023, we're adopting the revised CPT codes for Other E/M visits (except for prolonged services)…. We're finalizing Medicare-specific coding for prolonged Other E/M services and creating 3 new G codes (one per E/M family). These are:

- G0316 for reporting prolonged hospital inpatient or observation services
- G0317 for prolonged nursing facility services
- G0318 for prolonged home or residence services

Report prolonged cognitive impairment assessment services using G2212, the Medicare-specific code for prolonged office/outpatient services. Don't use CPT codes to report these services." (CMS[29])

CMS is not adopting "…CPT code 99418, as we believed that the billing instructions for CPT code 99418 would lead to administrative complexity, potentially duplicative payments, and limit our ability to determine how much time was spent with the patient using claims data; these reasons are discussed in further detail below. We instead proposed to create [are creating] a single G-code that describes prolonged inpatient or observation services, and that could be reported in conjunction with CPT codes 99223, 99233, and 99236. This G-code would be G0316…" (CMS[30])
[Note that G0317 and G0318 were also created for prolonged services in other settings of care.]

"Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service.

Medical symptoms and disorders inform treatment choices of 14psychotherapeutic interventions, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medial and psychotherapeutic components of the service may be separately identified as follows:

1. The type and level of E/M service is selected based on medical decision making.
2. Time spent on the activities of the E/M service is not included in the time used for reporting the psychotherapy service. Time may not be used as the basis of E/M code selection and prolonged services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported.
3. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service." (AMA[38])

"Questions and Answers: Evaluation and Management (E/M): E/M Services Guidelines
Medicine: Psychiatry

Question: What is the current guidance for reporting E/M services with psychotherapy codes 90833, 90836, and 90838? Per CPT coding conventions, time is not an allowable component for E/M code selection in this situation because psychotherapy services are time-based codes. Both services cannot be assigned based on time. However, the psychotherapy subsection guidelines do not reflect the 2021 changes to the criteria for E/M office visit code selection (medical decision making [MDM] or time). If health care professionals follow the 2021 guidelines for level selection for E/M services, they must use MDM to assign the E/M level of service. If they are allowed to follow the CMS 1995/1997 Documentation Guidelines for Evaluation and Management Services, they may use history, examination, and MDM. What is the correct criterion to use for E/M code selection?

Answer: MDM is the correct criterion for E/M level selection when E/M services are performed in conjunction with psychotherapy codes 90833, Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure), 90836, Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure), and 90838, Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure). Note that the instructions in the code descriptors for all these codes were reviewed by the CPT Editorial Panel at the February 2022 CPT Editorial Panel Meeting. Therefore, updates to the referenced language, if approved, will be included in the CPT 2023 code set." (AMA[39])

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Background Information

To address [“note bloat” within the patient record], on Feb. 9, 2019, the AMA CPT Editorial Panel convened a workgroup to revise the CPT E/M procedure codes, beginning with the office or other outpatient visit procedure codes. This work is in direct response to the leadership demonstrated by CMS Administrator, Seema Verma, to take on the challenge of revising the (E/M) office visit reporting guidelines.

“On Nov. 1, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized a historic provision in the 2020 Medicare Physician Fee Schedule Final Rule. This provision includes revisions to the Evaluation

and Management (E/M) office visit CPT® codes (99201-99215) code descriptors and documentation standards that directly address the continuing problem of administrative burden for physicians in nearly every specialty, from across the country." (AMA[21]) Over the next several years, both CMS and the AMA continued work on this project, both separately and in cooperation.

The new reporting guidelines and code descriptors for office and other outpatient visit E/M codes were effective January 1, 2021.

After these revisions were implemented, the CPT Editorial Panel approved, for 2023, additional revisions to the rest of the E/M code section. These revisions seek to provide continuity across all the E/M sections allowing for the revisions implemented in the E/M office visit section in 2021 to extend to all other E/M sections. New reporting guidelines and code descriptors for the remainder of the evaluation and management procedure codes have been released and are effective January 1, 2023.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
4/10/2024	Formatting/Update: Sections F & G: Corrected outline numbering problems. No content changes.
2/14/2024	Annual Review/Update: Definition of Terms: Added 2 entries; updated a third. References & Resources: 1 entry added.
6/14/2023	Clarification/update:

Date	Summary of Update
	Section D.1 updated & D.2 added with clarification of code selection & documentation of E/M services when combined with psychotherapy. Coding Guidelines: 2 entries added. References & resources: 2 entries added.
12/14/2022	Clarification/Update Header/Scope: Idaho added to States field. Title change & major revision to incorporate 2023 E/M changes. Added Determining Specialty For Non-Physician Practitioners (NPP) per provider inquiry on RPM041. Acronym table & Definition of terms: new additions. References & Resources: 21 entries added.
6/8/2022	Formatting & clarification/Update: Change to new header. Section A.4.c added in response to provider question. Acronym table: 6 entries added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
12/30/2020	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2021	Original Effective Date (with or without formal documentation). Policy based on joint CPT & CMS changes to E/M coding for outpatient E/M coding effective January 1, 2021.