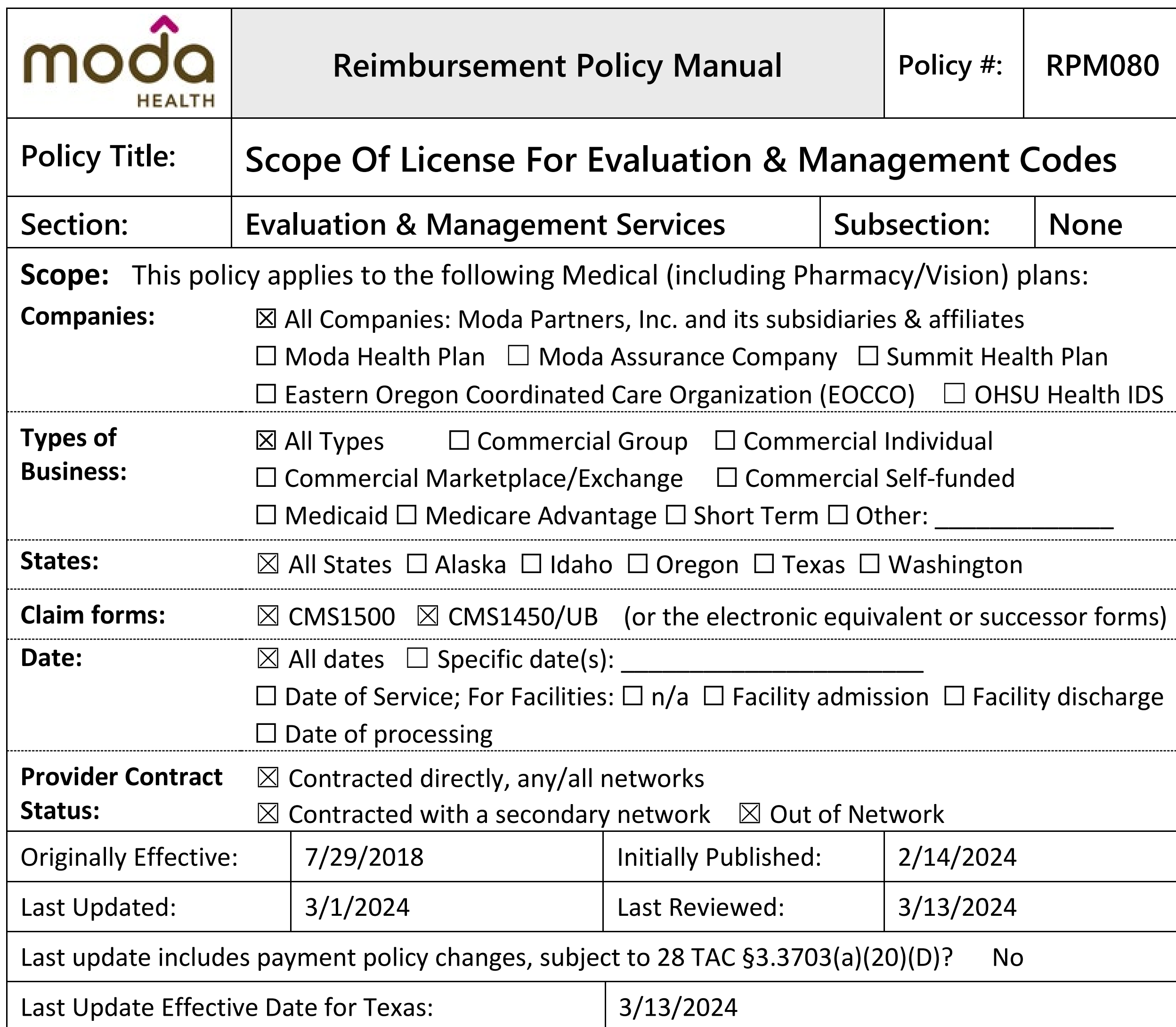

moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM080
Policy Title:	**Scope Of License For Evaluation & Management Codes**		
Section:	**Evaluation & Management Services**	**Subsection:**	**None**

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: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	7/29/2018	Initially Published:	2/14/2024
Last Updated:	3/1/2024	Last Reviewed:	3/13/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?	No		
Last Update Effective Date for Texas:	3/13/2024		

Reimbursement Guidelines

A. General

As an insurance carrier, one of our responsibilities to our providers, our members, our employer groups, and state and federal regulatory bodies includes confirming that providers are performing services and filing claims appropriately within their scope of practice and fulfilling the requirements of the billed procedure codes.

Our clinical edit system includes edits to ensure procedure codes with specific requirements are reported by appropriate providers. There are edits to address a variety of procedure codes to determine if the billing provider's scope of license does or does not encompass the key responsibilities required for the billed services.

This policy is intended to help clarify the requirements for performing the key responsibilities of an evaluation and management (E/M) service and the types of providers with a scope of license which includes the ability to perform and report E/M procedure codes.

B. Provider Must Be Qualified to Perform Billed Services

While the American Medical Association does not restrict the reporting of any CPT code to any specific licensure or specialty, they do make it clear that: (AMA[2])

1. The reporting provider must be qualified to perform the services represented by the procedure code. (AMA[2])
2. Scope of licensure and credentialing vary on a state-by-state and institutional basis. (AMA[2])
3. Third party payer guidelines may differ from the AMA's CPT coding guidelines.
    a. Eligibility for payment, as well as coverage policy, is determined by each individual insurer or third-party payer.
    b. Contact the appropriate third-party payer(s) for coverage and payment policies. (AMA[5, 6])

C. Evaluation and Management (E/M) Services

1. The evaluation and management section of the CPT book consists of procedure codes 99202 – 99499. These codes are divided into broad categories and subcategories. Each category may have specific guidelines, or the code descriptions may include specific details. (AMA[1])
2. Other evaluation and management procedure codes for specific situations (such as ophthalmological services, psychiatric diagnostic evaluation, etc.) are also available in other sections of the code sets.
3. An evaluation and management service from the evaluation & management section of the CPT book requires that a provider be qualified to perform Medical Decision Making.
4. Components of Medical Decision Making.
   Here is a summary of the major activities and elements of medical decision making gathered from multiple CPT Assistant articles issued and other resources posted by the AMA related to the 2021 and 2023 E/M code revisions and updated E/M guidelines: (AMA[5, 6, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20])
    a. Evaluation –
       Assessing and addressing a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter, by means of: (AMA[15])
        i. Review of history.
        ii. Examination.
        iii. Consulting independent historians (e.g., parent, guardian, spouse).
        iv. Ordering diagnostic studies (lab tests, radiology studies, etc.).
    b. Management – (AMA[15])
        i. Establishing & assigning a diagnosis.

           Per ICD-10-CM guidelines, if a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report diagnosis codes for sign(s) and/or symptom(s). (NCHS[21, 22])
        ii. Developing a treatment plan.
        iii. Managing risk of complications, morbidity, mortality.
        iv. Discussing findings, prognosis, and treatment options with patient.

v. Providing counseling regarding condition, treatment, or prevention measures as needed or appropriate.

vi. Ordering treatment(s) and/or prescriptions. Includes possible decision for surgery.

vii. Writing referrals.

5. Providers who report E/M procedure codes (99202 – 99499) must have a scope of license which allows them to fully perform medical decision making. Among other things, the provider's scope of license must include the ability to diagnose conditions, write orders for diagnostic tests to be performed, and prescribe (write orders for) medications and treatments.

D. Provider Types Qualified to Report E/M Services

The scope of practice of the following types of providers includes the key responsibilities of medical decision making, or there are specific guidelines from the cited national sources which authorize them to report E/M procedure codes under specific circumstances.

1. Physicians
   a. Medical Doctor (MD)
   b. Doctor of Osteopathic Medicine (DO)
   c. Doctor of Naturopathy (ND)
   d. Doctor of Naturopathic Medicine (NMD)
   e. Oral Surgeon (taxonomy 1223S0112X)
   f. Psychiatrist (taxonomy 2084P0800X)

2. Physician Assistant (PA)

3. Advanced practice nurses:
   a. Nurse Practitioner (NP)
   b. Clinical Nurse Specialist (CNS)
   c. Certified Nurse Midwife (CNM)
   d. Certified Professional Midwife (CPM)
   e. Certified Registered Nurse Anesthetist (CRNA) (CMS[23], OSBN[24])

4. Pharmacist (R.Ph., D.Ph., Pharm.D.) for the following member plans only:
   a. Oregon Medicaid plans. (OHA[28])
   b. Oregon Commercial plans. (Moda[29])

E. Provider Types Not Qualified to Report E/M Services

The scope of practice of the following types of providers does not include medical decision making, so these providers are not eligible to report evaluation and management procedure codes. (This list includes examples which have generated provider inquiries but is not necessarily exhaustive.)

1. Dentists (DDS, DMD)
   a. Based upon statements from Noridian and CMS, only dentists who are also oral surgeons may bill E/M procedure codes. (Noridian[25, 26], CMS[27])
   b. A provider education letter was mailed to Dental for Medical providers on February 21, 2024. A copy of this letter is included as an Attachment.

2. Registered Nurse (RN, not advanced practice)

3. Behavioral/mental health providers, any and all who are not a Psychiatrist (MD); this includes but is not limited to:

a. Psychologist (Psy.D.)
b. Licensed Clinical Professional Counselor (LCPC)
c. Licensed Clinical Mental Health Counselor (LCMHC)
d. Licensed Clinical Social Worker (LCSW)
e. Licensed Mental Health Counselor (LMHC)
f. Licensed Mental Health Practitioner (LMHP)
g. Licensed Professional Counselor (LPC)
h. Licensed Professional Clinical Counselor of Mental Health (LPCC)
i. Marriage and Family Therapist (MFT)

4. Lactation specialists, counselors, and consultants (BFC, CBC, CLC, CLE, LC, IBCLC, etc.)
5. Dieticians (RD)
6. Physical Therapist (PT)
7. Occupational Therapist (OT)
8. Pharmacist (R.Ph., D.Ph., Pharm.D.) outside the State of Oregon
9. Acupuncturist (AC)
10. Clinic
    In general, providers listing clinic taxonomies are not eligible to report E/M services. E/M procedure codes need to be submitted under the individual provider performing the service so that their taxonomy (and thus scope of license) can be evaluated during claim adjudication.

F. Clinical Edits

1. Our system includes clinical edits which evaluate whether or not the billing provider type is appropriate for the procedure code submitted.
    a. The clinical edits for provider type appropriate for procedure code address a variety of procedure codes, including anesthesia, maternity delivery, professional and technical components, E/M services, home infusion, audiology, and more.
    b. This policy focuses specifically on this editing for E/M services.
    c. These clinical edits utilize the provider taxonomy in our provider record.
        i. The taxonomy code listed in our provider records is collected from or validated against the National Plan and Provider Enumeration System (NPPES).
        ii. Any provider who holds a dual specialty or dual licensure (e.g., dentist and oral surgeon, or Registered Nurse and Nurse Practitioner) is advised to select the taxonomy of their highest license or specialty as their primary taxonomy in NPPES, as this will be used to validate your provider record and process your claims.
2. Line items which trigger these clinical edits will deny to provider liability with one of the following denial codes:

u08	This provider type/provider specialty may not bill this service.
z03	This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider.

835 CARC/RARC denial combinations:

CARC 170	Payment is denied when performed/billed by this type of provider.
RARC N95	This provider type/provider specialty may not bill this service.

CARC 8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
RARC none	n/a

G. Steps to Remedy Denials for Provider Type Inconsistent With Procedure

If you receive a denial which indicates your provider type is inconsistent with the billed service, the following steps may be taken to remedy the denial.

1. Carefully review this policy in its entirety.
2. If you are one of the provider types qualified to report E/M services, then:
   a. Confirm your taxonomy code listed in the NPPES system is correct.
   b. If you hold a dual licensure, confirm that your highest licensure is listed in NPPES as your primary taxonomy.
   c. Contact your provider representative at Moda to request that your provider record be updated to be consistent with your taxonomy listed in NPPES and request that denied claims are reprocessed when the record update is completed.
3. If you are one of the provider types not qualified to report E/M services, a corrected claim will need to be submitted.
   a. Replace the E/M procedure code with the appropriate procedure code to report the services provided.
   b. In most instances, clinics will need to submit the services under the individual provider performing the E/M service rather than under the general clinic entity.

H. Procedure Codes Available to Provider Types Not Qualified to Report E/M Services

1. We will accept the procedure codes listed in the table below from provider types not qualified to report E/M services.
   a. This is not intended to be a comprehensive list of all possible procedure codes for provider types not qualified to report E/M codes.
   b. Not all of these procedure codes will be appropriate for all types of providers or certifications.
   c. You are responsible for selecting the most accurate and appropriate procedure code to report the services you provide, and for accurately documenting your services. The medical record must support the procedure code(s) reported. (Moda[C])

2. The submitting provider's licensure, certification, and training is expected to qualify them to address or counsel patients on the topics addressed (e.g., smoking cessation, diabetes, cancer, lactation needs, etc.).
3. The member's plan benefits and exclusions also apply.

Procedure codes accepted from providers not qualified to report E/M codes (not all-inclusive)	
Code	**Code Description**
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96158*	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159*	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96160*	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161*	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
96164*	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165*	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167*	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168*	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96170*	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
96171*	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)
G0444	Annual depression screening, 5 to 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes

Procedure codes accepted from providers not qualified to report E/M codes (not all-inclusive)	
Code	**Code Description**
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
S3005	Performance measurement, evaluation of patient self-assessment, depression
S9443	Lactation classes, nonphysician provider, per session
S9445	Patient education, not otherwise classified, nonphysician provider, individual, per session
S9452	Nutrition classes, nonphysician provider, per session
S9453	Smoking cessation classes, nonphysician provider, per session
S9454	Stress management classes, nonphysician provider, per session
S9455	Diabetic management program, group session
S9460	Diabetic management program, nurse visit
S9465	Diabetic management program, dietitian visit
S9470	Nutritional counseling, dietitian visit

*Note:
Health behavior assessment and intervention (HBAI) services (96156 - 96171) do not represent a behavioral health service. Instead, the patient's primary diagnosis is physical in nature and the focus of the assessment and intervention is on identifying and addressing the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. (AMA[31])

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		**Definition**
AMA	=	American Medical Association
APP	=	Advanced practice provider (non-Medicare term)
BFC	=	Breastfeeding Counselor
CBC	=	Certified Breastfeeding Counselor
CCI	=	Correct Coding Initiative (see "NCCI")
CLC	=	Certified Lactation Counselor
CLE	=	Certified Lactation Educator
CMS	=	Centers for Medicare and Medicaid Services
CNM	=	Certified Nurse Midwife
CNS	=	Clinical Nurse Specialist
CPM	=	Certified Professional Midwife
CPT	=	Current Procedural Terminology

Acronym or Abbreviation		Definition
CRNA	=	Certified Registered Nurse Anesthetist
DDS	=	Doctor of Dental Surgery
DMD	=	Doctor of Dental Medicine, Doctor of Medicine in Dentistry
DO	=	Doctor of Osteopathic Medicine
D.Ph.	=	Doctor of Pharmacy
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HBAI	=	Health Behavior Assessment And Intervention services
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
IBCLC	=	International Board Certified Lactation Consultant
LC	=	Lactation Counselor
LCMHC	=	Licensed Clinical Mental Health Counselor
LCPC	=	Licensed Clinical Professional Counselor
LMHC	=	Licensed Mental Health Counselor
LMHP	=	Licensed Mental Health Practitioner
LPC	=	Licensed Professional Counselor
LPCC	=	Licensed Professional Clinical Counselor of Mental Health
MD	=	Medical Doctor
MDM	=	Medical Decision Making
MFCC	=	Marriage, Family, and Child Counselor
MFT	=	Marriage and Family Therapist
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
NCHS	=	National Center for Health Statistics
ND	=	Doctor of Naturopathy
NMD	=	Doctor of Naturopathic Medicine
NP	=	Nurse Practitioner
NPP	=	Non-physician Practitioner (Medicare terminology)
NPPES	=	National Plan and Provider Enumeration System
OT	=	Occupational Therapist

Acronym or Abbreviation		Definition
PA	=	Physician Assistant
Pharm.D.	=	Doctor of Pharmacy
Psy.D	=	Psychologist
PT	=	Physical Therapist
QHCP	=	Qualified Health Care Professional
RD	=	Registered Dietician
R.PH.	=	Registered Pharmacist
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
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 clinical staff member is 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 professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services. (AMA[7, 8, 9])
Medical Decision Making (MDM)	MDM refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the following elements: • The number and complexity of problems addressed at the encounter. • The number of possible diagnoses and/or the number of management options that must be considered. • The amount and/or complexity of data to be reviewed and analyzed. • The risk of significant complications, morbidity, and/or mortality of patient management. (AMA[15])

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[10]) 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[7, 8, 9]) Other qualified health care professionals consist of Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Midwives, and Certified Registered Nurse Anesthetists (CRNA).
Physician	A "physician or other qualified health care professional" is an individual who 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[7, 9]) Physicians consist of Medical Doctors (MD), Doctor of Osteopathic Medicine (DO), and Naturopathic Physicians (ND, NMD).

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

"As with other sections of CPT…These codes are not restricted to use by a specific specialty group. Instead, these codes may be used by any provider who is qualified to perform the service represented by the specific code. No distinction is made concerning the licensure or professional credentials of the provider. Licensure and credentialing vary on a state-by-state and institutional basis. Appropriate state and institutional authorities should be consulted regarding the appropriate provision of these services by health care professionals." (AMA[2])

Note: The following coding Q & A refers specifically to lactation consultation services performed by a nurse in a clinic under the supervision of a physician, not to an independent lactation consultant who is not a registered nurse and not working under the supervision of a physician.

"**Frequently Asked Questions - Evaluation and Management (E/M): Office or Other Outpatient Services**

Question: What is the most appropriate Current Procedural Terminology (CPT ®) code to report lactation consultation services performed by a nurse in the clinic after delivery?"

Answer: A physician or other qualified heath care professional (QHP) may report code 99211, *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.* Usually, the presenting problem(s) are minimal, for services performed by a nurse. An advanced practice provider (APP), physician, or other QHP may report the full range of E/M

codes, when appropriate, such as when there is a need to assess and manage lactation or feeding problems. The CPT code set does not include routine lactation counseling services as part of postpartum care, although this routine counseling may be considered as part of antepartum care.

Note: CPT coding guidelines may differ from third party payer guidelines. Eligibility for payment, as well as coverage policy, is determined by each individual insurer or third-party payer. Contact the appropriate third-party payer(s) for coverage and payment policies." (AMA[5])

"The purpose of this article is to review and elaborate upon the appropriate use of E/M codes for reporting physician preventive medical services. These services include the "periodic or annual physical" for infants, children and adults, counseling and/or risk factor reduction, intervention and the administration of health risk assessment instruments.…

The following codes are used to report the routine evaluation and management of adults and children when these services are performed in the absence of patient complaints. The extent and focus of the services will largely depend on the age of the patient, the circumstances of the examination, and the abnormalities encountered.

Codes 99381-99397 do not include counseling, risk factor reduction interventions or immunizations. If risk management services are provided at the same session as a preventive medicine visit, both codes should be reported. For counseling and/or risk factor reduction interventions, see 99401-99412. For immunizations, see 90701-90749.…

The Preventive Medicine Services codes provide a means to report a routine or periodic history and physical examination in asymptomatic individuals. These codes are used to report the E/M services (i.e., comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures) that are provided to the patient. They include only those evaluation and management services related to the age specific history and examination provided by the physician. They do not include counseling and/or risk factor reduction intervention nor do they include the provision of immunizations.**"** (AMA[3])

"Defining Counseling

CPT defines counseling as it relates to E/M coding as a discussion with a patient and/or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction; and
- patient and family education.

Counseling vs. Psychotherapy

The counseling as defined above is not to be confused with psychotherapy. Psychotherapy is the treatment for mental illness and behavioral disturbances, in which the clinician establishes a professional contract with the patient related to the resolving of the dynamics of the patient's problems and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances,

reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

A patient receiving psychotherapy may also receive separate counseling related to areas such as laboratory findings, drug reactions, or treatment options. This counseling is separate and distinct from psychotherapy provided to treat mental illness.

Preventive Medicine Counseling

Specific codes are available in the preventive medicine services section of CPT for reporting preventive medicine counseling. Codes from the 99401-99412 series are used to report counseling services provided to individuals at a separate encounter for the purpose of promoting health and preventing illness or injury.…

Counseling and/or risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination are included in the preventive medicine E/M service and not reported separately." (AMA[4])

"Third-party payer reporting guidelines may differ from CPT coding guidelines, as both coverage and payment policy are determined by individual insurers and thirdparty payers. For reimbursement or third-party payer policy questions, contact the appropriate payer. Note that third-party payers may have additional information and requirements when reporting time." (AMA[6])

"CPT codes for E&M services are principally included in the CPT code range 99202-99499. The codes describe the site of service (e.g., office, hospital, home, nursing facility, emergency department, critical care), the type of service (e.g., new or initial encounter, follow-up or subsequent encounter), and various miscellaneous services (e.g., prolonged physician service, care plan oversight service)….Certain sections of CPT codes include codes describing specialty-specific services which primarily involve E&M services. When codes for these services are reported, a separate E&M service from the range of CPT codes 99202-99499 shall not be reported on the same date of service. Examples of these codes include general and special ophthalmologic services and general and special diagnostic and therapeutic psychiatric services." (CMS[11])

"Key Concepts and Definitions

In the 2021 E/M guidelines, a problem is defined as a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter noted at the encounter, with or without a diagnosis being established at the time of the encounter. A problem is considered to be addressed or managed when it is evaluated or treated at the encounter by the physician or other QHP 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.

Situations that do not qualify as being addressed or managed by the physician or other QHP reporting the service include the following:

- Notation in the patient's medical record that another professional is managing the problem without documenting additional assessment or care coordination
- Referral without evaluation (by history, examination, or diagnostic study[ies] or consideration of treatment)" (AMA[15])

"Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0-R99) contains many, but not all, codes for symptoms.

See Section I.B.18. Use of Signs/Symptom/Unspecified Codes." (NCHS[21])

"If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis." (NCHS[22])

"Dentists, if he/she is an oral surgeon, may bill an Evaluation and Management (E/M) code; however, if a consultation is performed with the beneficiary before services are rendered, this is considered part of the surgery and is not separately billable." (Noridian[26])

"Medicare will pay for E/M services for specific, non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS), and certified nurse midwife (CNM)), whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service; however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary, and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice." (CMS[27])

" Health behavior assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. The patient's primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the patient's health and well-being utilizing psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems.

Health behavior assessment: includes evaluation of the patient's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Assessment is conducted through health-focused clinical interviews, observation, and clinical decision making.

Health behavior intervention: includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement an involvement. These interventions may be provided individually, to a group (two or more patients), and/or to the family, with or without the patient present.

Codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the psychological and/or psychosocial factors related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions." (AMA[31])

Cross References

A. "2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services." Moda Health Reimbursement Policy Manual, RPM076.

B. "E0486 Oral Sleep Apnea Device/Appliance Documentation & Bundled Services." Moda Health Reimbursement Policy Manual, RPM055.

C. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

D. "Preventive Medicine & Problem-Oriented E/M Visits, Same Day." Moda Health Reimbursement Policy Manual, RPM078.

References & Resources

1. AMA. "E/M Guidelines Overview." CPT book, Professional Edition, page 4 (new or revised text in 2023 edition).

2. AMA. "A Comparative Look at the Physical Medicine and Rehabilitation Codes." CPT Assistant, December 1998, page 1.

3. AMA. "Coding Tip – Evaluation and Management Codes for Preventive Services." CPT Assistant, Spring 1993, page 14.

4. AMA. "Coding Communication – Coding for Counseling." CPT Assistant, January 1998, page 5.

5. AMA. "Frequently Asked Questions - Evaluation and Management (E/M): Office or Other Outpatient Services." CPT Assistant, Volume 31 Issue 2, February 2021, page 13.

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Background Information

As an insurance carrier, one of our responsibilities includes confirming that providers are performing services and filing claims appropriately within their scope of practice and fulfilling the requirements of the billed procedure codes. Insurance carriers are also subject to audits by employer groups and state and federal regulatory bodies. Our clinical editing system includes clinical edits which evaluate whether or not the billing provider type is appropriate for the procedure code submitted for a variety of procedure codes.

As various sources brought to our attention that we were allowing E/M procedure codes to provider types whose Scope of License or Certification is not consistent with the E/M code definitions and responsibilities, in 2021 we began to develop and implement clinical editing for provider type inconsistent with E/M services. These edits continue to be updated and refined on an ongoing basis to consider new information brought to our attention by various sources.

We have received a significant number of inquiries and appeals on clinical edit denials of E/M procedure codes for *Provider Type Inconsistent With the Billed Service* from a variety of provider types, certifications, and licensures. This policy was developed as a document for public posting as part of our efforts to clarify the sources and rationale behind the clinical edit denials and to help educate providers on how to both address any denials experienced and avoid similar denials in the future.

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
3/13/2024	Clarification/Update: Header: Added missing Initial Publication date. Section E.1.b: Added with hyperlink to newly added Attachment. Attachment: Newly added containing copy of provider education letter directed towards Dental for Medical providers, sent February 21, 2024.
2/14/2024	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
12/15/2020	Custom edit specific to provider type inappropriate for E/M codes installed into production. Based on E/M code definitions & guidelines and scope of license requirements.
7/29/2018	Original Effective Date (with or without formal documentation). Policy based on upgrade to new clinical edit system which contains edits for provider type inappropriate for procedure.

Attachment

PO Box 40384
Portland, OR 97240

February 21, 2024

Provider/Clinic
Name Street
Address
City, State ZIP code

Dear Provider,

Moda has received a significant number of inquiries and appeals on clinical edit denials of Evaluation and Management (E/M) procedure codes for *Provider Type Inconsistent with the Billed Service*. We would like to offer clarification of both the edit sourcing and recommended steps to review the denial when received.

As an insurance carrier, one of our responsibilities to our providers, our members, and our employer groups includes confirming that providers are performing services and filing claims appropriately within their scope of practice and fulfilling the requirements of the billed procedure codes.

We began work to develop and implement clinical editing in 2021 to align with this responsibility with a focus on E/M procedure codes. Various sources brought to our attention that we were allowing E/M procedure codes to providers whose Scope of License or Certification is not consistent with the E/M procedure code definitions and responsibilities of performing evaluation, diagnosis, and prescribing/treatment management functions of E/M medical decision making for medical conditions. The clinical edit utilizes the taxonomy code listed in our provider record, collected from the NPPES system, to determine denial scenarios. Note, if you have dual licensure/certifications, please ensure your primary taxonomy listed reflects your highest level of certification or scope of license.

Moda recognizes that we previously have allowed E/M procedure codes to providers who are now experiencing this denial. These changes occur as the clinical editing continues to be updated and refined periodically to consider new information brought to our attention by various sources. A significant update occurred on 10/26/22. This editing remains under active review and development to ensure we continue to be in alignment with the best information available regarding these requirements.

Although this clinical edit has affected a variety of provider types, we recognize that our Dental-for-Medical providers have been frequently affected by denials of E/M procedure codes for inconsistent provider type. Based

upon statements from LCD L33611, Article A53446, Noridian, and in CMS Pub. 100-04, ch. 12, § 30.6.1.A only dentists who are also oral surgeons may bill E/M procedure codes. Accordingly, dentists utilizing other taxonomies in the NPPES registry will receive denials of E/M procedure codes and are expected to bill dental-specific codes (Dxxxx) for any office visits for observation, evaluation, re-evaluation, etcetera.

If you are receiving denials on E/M procedure codes for *Provider Type Inconsistent with the Billed Service*, please first confirm your taxonomy code listing in NPPES reflects the correct specialty. Also, any provider who holds a dual specialty or dual licensure (e.g., dentist and oral surgeon, or Registered Nurse and Nurse Practitioner) is advised to select the taxonomy of their highest license or specialty as their primary taxonomy in NPPES, as this will be used to validate your provider record and process your Moda claims. Then contact your provider representative to request that your provider record be checked to ensure your taxonomy code matches your NPPES taxonomy listing. Should NPPES and Moda systems be consistent, please review resources included in the CPT and CMS manuals in conjunction with local state guidance for scope of license limitations.

Some of our provider contracts may still utilize older language and templates that may lead to questions on this topic. If this is the case for your provider contract and you wish to address it, please reach out to your Contract Representative to start the process of updating the provider contract to the most recent language regarding E/M codes for dentists and other providers.

Regarding E/M services provided in connection with oral sleep apnea appliances: please note that our provider contracts for this utilize a bundled case rate that includes payment for any needed visits before or after the appliance is issued. A specialty of oral surgeon does not change the bundling of E/M visits into the contracted case rate. Please reference both your provider contract for oral sleep apnea appliances and "E0486 Oral Sleep Apnea Device/Appliance Documentation & Bundled Services." Moda Health Reimbursement Policy #RPM055.

Questions?
We're here to help! Please call our Provider Relations team via email at providerrelations@modahealth.com.

Together, we can be more. We can be better.

Sincerely,

Your Moda Health Provider Relations Team