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 1995/1997 CMS 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.

The descriptors for the levels of E&M services recognize the following seven components, which are used in defining the levels of E/M services:

- History
- Examination
- Medical decision-making
- Counseling
- Coordination of care
- Time factor
- Nature of presenting problem

Harvard Pilgrim recognizes CPT's definition of services inclusive to E&M services which includes examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, for example, the determination of the need and/or location for appropriate care.

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.

As of date of service 12/15/2017 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.

Prior to date of service 12/15/2017:

- Reimbursement for more than one outpatient E&M service provided on the same day by providers of the same specialty within the same group will be reimbursed if the providers have different subspecialties.
  - Example: A member is seen in the office by an Internal Medicine physician with a subspecialty of cardiology and is also seen by another internal medicine physician with a subspecialty of rheumatology within the same group.
- Reimbursement for more than one inpatient E&M service provided on the same day by providers of the same specialty within the same group will be reimbursed if the providers have different subspecialties and the member is seen for an unrelated diagnosis.
  - 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

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rate, and reimbursement for the lower valued service will be made at 50% of the contracted allowable rate. This should only occur when a significant abnormality or pre-existing condition is addressed, and additional work is 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, 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.

Consultations

- Physician consultation services are for an opinion or advice relating to evaluation of a known or suspected problem, subject to applicable referral requirements.
- A PCP for outpatient office consultation to his/her own member/patient for pre-operative surgery clearance consults only. Outpatient office consultations will not be reimbursed for any other indications (i.e., post-operative or non–surgery-related consults).
  - Harvard Pilgrim will not reimburse pre-operative surgery clearance if the same PCP has been reimbursed for a consult to his/her own patient for the same or related condition or diagnosis. Medical records must support reported level of service. Consultation services will be monitored to ensure appropriate documentation and billing (may be subject to random post-payment audit and retraction).

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.

Telephone E&M Services

Harvard Pilgrim reimburses two telephone E&M services (5–10 minutes of medical discussion) per calendar year for members with associated behavioral health diagnosis, for the purposes of medical management. Telephone E&M services must be documented in the member's medical record.

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.

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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 include the use of facsimile or audio-only telephone.

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.
- Consultations (CPT 99241-99245) if the same provider has billed any other E/M service, in any place of service, for the same member in the previous 12 months.
- 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.
- Generic supplies (A specific HCPCS code must be submitted for reimbursement consideration.)
- Handling fees, device handling, or telephone E&M services (11–30 minutes of medical discussion).
- 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 a consult to his/her own patient for the same or related condition or diagnosis. Medical records must support reported level of service. Consultation services will be monitored to ensure appropriate documentation and billing (may be subject to random post-payment audit and retraction).
- Prolonged service. (This may be reimbursed only after individual consideration based on notes that document and reflect time spent.)
- Provider travel time and/or expenses.
- Routine blood draws when billed with an E&M.
- Services defined by CPT as included in the definition of patient transport codes.
- Telephone E&M services submitted by the same provider 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
36410, 36415	Routine blood draws	Not separately reimbursed when billed with laboratory/ E&M services
36416	Collection of capillary blood specimen	Not reimbursed

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Code	Description	Comments
36620	Insertion of an arterial catheter	Separately reimbursed when billed with an emergency department E&M code
93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting INR test results, and documentation of patient's/caregiver's ability to perform testing and report results	
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	
94640	Airway inhalation treatment	Not reimbursed when billed with an inpatient E&M service
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	
98966–98968	Telephone assessment and management service provided by a qualified non-physician health care professional; 5–10; 11–20 or 21–30 minutes of medical discussion	Not reimbursed
99000, 99001	Handling fees	
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	
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
99177	Instrument-based ocular screening (e.g., photo screening, automated-refraction), bilateral; with on-site analysis	
99221–99239	Inpatient E&M service codes	

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Code	Description	Comments
99241–99255	Consultation E&M service codes	Reimbursable to PCPs for pre-operative surgery clearance consults only when submitted with primary diagnosis codes: **ICD-10 Covered Indications**
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
99304–99306	Initial nursing facility care	
99307–99310	Subsequent nursing facility care	
99315–99316	Nursing facility discharge services	
99318	Annual nursing facility assessment	
99341–99350	Physician home services	
99354, 99357	Prolonged services	Not reimbursed; may be appealed for reimbursement after individual consideration of notes which must reflect the time spent face-to-face with the patient
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.
99406–99407	Smoking and tobacco use cessation counseling visit; intermediate (3–10 minutes) or intensive (greater than 10 minutes)	
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
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Not reimbursed, provider is liable
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Not reimbursed, provider is liable
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 21 or more minutes	Not reimbursed, provider is liable

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Code	Description	Comments
99441	Telephone E&M service, 5–10 minutes of medical discussion	Reimbursed for adult members, 18 and older, billed with associated primary behavioral health diagnosis codes consistent with a new episode of depression: **ICD-10 Covered Indications** For pediatric members, 6–12 years, billed with associated primary behavioral health diagnosis codes consistent with a diagnosis of ADD/ADHD: **ICD-10 Covered Indications**
99442, 99443	Telephone E&M services, 11–30 minutes of medical discussion	Not reimbursed
99446-99449	Interprofessional telephone/internet assessment and management service provided by a consultative physician	Reimbursed for facility only
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 — effective for dates of services on or after 01/01/16
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
G0372	Physician services required to establish and document the need for a power mobility device (PMD)	Not reimbursed
G0406-G0408	Follow-up inpatient consultation	
G0508-G0509	Telehealth consultation — critical care,	

Other Information

Significant and separately identifiable E&M services must be reported with the modifier 25 if provided on the same day as diagnostic pulmonary services, or injection/infusion administration services (other than CPT 99211).

Related Policies

- Anesthesia Payment Policy
- CPT & HCPCS Level II Modifiers Payment Policy
- Home Health Care Payment Policy
- Home Health Care Policy Medical Review Criteria
- Hospital-based Clinic Payment Policy
- Molecular Diagnostic Management Policy Medical Review Criteria
- Surgery Payment Policy
- Telemedicine/Telehealth Payment Policy

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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

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, 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.