EVALUATION AND MANAGEMENT SERVICES

Policy

AllWays Health Partners reimburses participating providers for the provision of medically necessary evaluation and management (E/M) services, including specialist visits and second opinions.

AllWays Health Partners follows the 1995/1997 CMS documentation guidelines for E/M services. Medical records must support reported levels of services based on these guidelines. Please reference the most current version of the American Medical Association (AMA) CPT-4 Manual for complete descriptors of E/M codes and instructions for selecting a level of service.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the AllWays Health Partners Payment Policy and by the provider's agreement with AllWays Health Partners. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

AllWays Health Partners reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to General Coding and Billing for more information.

All claims are subject to audit services and medical records may be requested from the provider.

AllWays Health Partners reimbursement is based on line of business.

AllWays Health Partners Does *Not* Reimburse

Note: This list may not be all-inclusive and is subject to change

- Adjunct codes reported in addition to the basic service rendered, including codes for medical services provided from 10:00pm to 8:00am at a 24-hour facility; or out-of-the-office; or on an emergency basis out-of-the-office
- An emergency department E/M service billed with critical care services rendered by the same provider on the same date of service or telehealth consultation
- Consultation codes (99241-99245, 99251-99255)
- E/M services within the global period of a procedure
- Established patient E/M services on the same day as a surgical procedure unless there is a significant, separately identifiable E/M service appended with the appropriate modifier
- Generic and/or special supplies
- Handling fees
- Inpatient consultations (99221-99223, 99231-99233) when the consulting provider is not face-to-face with the patient in the facility
- Medical testimony, special reports or forms, or computer data analysis
- Out of hospital on-call services
- Prolonged physician services
- Services identified by CPT as included in the descriptor as pediatric critical care services
- Unusual physician travel

Procedure Codes

Note: This list of codes may not be all-inclusive

Code(s)	Short Descriptor	Comments
36415	Routine blood draw	Not separately reimbursable when billed with laboratory or E/M codes
36416	Collection of capillary blood specimen	Not reimbursable
96040	Genetic counseling services; 30 minutes	
99000-99002	Specimen handling	Not reimbursable
99024	Post-operative follow-up visit	Not reimbursable
99026-99027	Hospital mandated on call service	Not reimbursable
99050	Services provided in the office at times other than regularly scheduled business hours, or days when the office is normally closed; in addition to basic service	Report in conjunction with designated E/M level visit; not reimbursable for Urgent Care Centers

99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours; in addition to basic service	Not reimbursable
99053	Services provided between 10:00PM and 8:00AM at 24-hour facility; in addition to basic service	Not reimbursable
99056	Services typically provided in the office, provided out of the office at request of the patient; in addition to basic service	Not reimbursable
99058	Office emergency care which disrupts other scheduled office visits	Not reimbursable
99060	Services provided on an emergency basis, out of the office, which disrupts other scheduled office services; in addition to basic service	Not reimbursable
99070	Supplies and materials provided by the physician	Not reimbursable
99075	Medical testimony	Not reimbursable
99080	Special reports or forms	Not reimbursable
99082	Unusual travel	Not reimbursable
99090	Computer data analysis	Not reimbursable
99173	Visual acuity screening test	Not separately reimbursable when billed with E/M codes
99201-99205	Office or other outpatient visit; new patient	
99211-99215	Office or other outpatient visit; established patient	
99217-99220	Observation care	Please refer to Observation Services Payment Policy
99224-99226	Observation care; subsequent day	Please refer to Observation Services Payment Policy
99221-99223	Inpatient services; initial care	Please refer to Inpatient Hospital Admissions
99231-99233	Inpatient services; subsequent care	
99234-99236	Observation or Inpatient hospital care	
99238-99239	Hospital discharge services	
99241-99245	Office consultations	Not reimbursable; report with appropriate complexity level office visit E/M code
99251-99255	Inpatient consultations	Not reimbursable; report with appropriate complexity level hospital inpatient E/M code
99281-99285	Emergency department services	
99288	Physician direction of advanced life support	Not reimbursable

99291-99292	Critical care services	Report initial service (30-74 minutes) with CPT code 99291 with a count of one unit. Report each additional 30 minutes as one unit using CPT 99292.
99304-99306	Nursing facility services; initial	
99307-99310	Nursing facility services; subsequent	
99315-99316	Nursing facility discharge services	
99318	Annual nursing facility assessment	
99324-99328	Domiciliary/rest home services; new patient	
99334-99337	Domiciliary/rest home services; established patient	
99339-99340	Domiciliary/rest home services; care supervision	
99341-99345	Physician home services; new patient	
99347-99350	Physician home services; established patient	
99354-99357	Prolonged services with direct patient contact	Not reimbursable
99358-99359	Prolonged services without direct patient contact	Not reimbursable
99360	Standby services	Not reimbursable
99363-99364	Anticoagulation management services	Report for outpatient management services only. Do not report in conjunction with an E/M or care plan oversight code for this service.
99366	Medical team conference; direct contact	Not covered
99367-99368	Medical team conference; without direct contact	Not covered
99374-99380	Care plan oversight services	
99381-99387	Preventive medicine services; new patient	
99391-99397	Preventive medicine services; established patient	
99401-99404	Preventive medicine counseling	
99406-99409	Behavior change interventions	
99411-99412	Preventive medicine group counseling	
99429	Unlisted preventive service	Not reimbursable; submit with appropriate evaluation and management code
99441-99443	Telephone services; non-face-to-face	Not Reimbursable
99444	Online medical evaluation	Not Reimbursable
99466-99467; 99485-99486	Pediatric critical care during the inter-facility transport	Please refer to Newborn Care Payment Policy
99468-99469	Neonatal critical care age <28 days	Please refer to Newborn Care Payment Policy

99471-99472	Pediatric critical care, age 29 days through 24 months	Please refer to Newborn Care Payment Policy
99475-99476	Pediatric critical care, age 2-5 years	Please refer to Newborn Care Payment Policy
99499	Unlisted evaluation and management service	Not reimbursable; submit with appropriate evaluation and management code
A4580, A4590; Q4001-Q4051	Casting supplies	Not reimbursable
G0425-G0427	Physician evaluation and management of a diabetic patient with diabetic sensory neuropathy	Not reimbursable; submit with appropriate evaluation and management code

Modifiers

Category	Comments
Preventive Medicine and Problem-Focused E/M Services	• Reimbursement is made for two different E/M services on the same day, only when a provider submits a problem-focused office visit procedure code with a preventive medicine procedure code and the appropriate modifier is appended to the problem-focused code
Multiple Problem-Focused E/M Services	• Reimbursement is made for more than one E/M procedure code for a single date of service when such services are rendered by providers, including mid-level practitioners, of different specialties • Only one E/M service is allowed for a single date of service for the same provider group (same TIN) and same specialty, regardless of place of service • Exception: Obstetrical care - Clinicians in the same practice, or back-up physicians, coverage providers including physicians, nurse midwives, physician assistants, or nurse practitioners that are owners, partners, employees, or contracted staff at the practice may provide components of the care but are not separately reimbursed.
E/M Services within a Global Period	• Reimbursement is made for E/M services rendered during the global period when the service is distinct and unrelated to the primary procedure and supported by the documentation.
Critical Care Services	• Reimbursement is not be made for any E/M service when billed with a critical care service
Telemedicine	• Reimbursement is made for certain E/M services when performed via telemedicine. Refer to the Telemedicine Payment Policy for more information.

Related Documents

General Coding and Billing
Modifiers
Newborn Care Payment Policy
Observation Services Payment Policy
Preventive Services Payment Policy
Telemedicine Payment Policy

References

1995 CMS Documentation Guidelines for Evaluation and Management Services
1997 CMS Documentation Guidelines for Evaluation and Management Services
Current year CPT, Professional Edition published by the AMA (American Medical Association)
CMS Global Surgery Fact Sheet

Publication History

Topic: Evaluation and Management	Owner: Network Management

April 12, 2010	*Original documentation*
April 19, 2011	*Updated authorization grid, smoking cessation, new 2011 CPT code, references*
July 8, 2011	*Corrected observation code numbers updated "AllWays Health Partners Does Not Reimburse", updated code grid to include: 99354-99359, and updated 99058 to require documentation*
August 29, 2011	*Corrected range 99221-99223, 99231-99239, 99147-99150, added procedure code grid, non-coverage of consult codes, and references changed.*
August 1, 2013	*Policy name change, authorization grid, and added HCPCS G0436 for GIC tobacco cessation services, CPT 99024 added to grid as not reimbursed, CPT 99051 and 99058 updated to not reimbursed*
February 1, 2014	*Policy updated to reflect NCCI Mod 25 E/M rules effective Jan 1, 2013, expanded code list of telehealth services*
February 1, 2017	*Document restructure, code review and changes, complexity and separation to the categories of E/M, telehealth codes 99441-99443 added, inpatient E/M codes were corrected, removed definition, removed/added references, added related AllWays Health Partners payment guidelines, added hyperlinks*
July 15, 2017	*Code review; change to telemedicine reimbursement information; addition to Related Documents links*
January 01, 2019	*Document restructure; codes, code descriptor and references updated*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. AllWays Health Partners utilizes clinical coding criteria and claim editing logic in addition to auditing across dates of service to identify the unbundling of pre and post-operative care.

AllWays Health Partners includes AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company.