If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Oklahoma may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Evaluation and Management Coding – Professional Provider Services

Policy Number: CPCP024

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: August 7, 2024

Plan Effective Date: November 18, 2024

Description

This policy applies to professional providers (physicians or other Qualified Healthcare Professionals) who bill for Evaluation and Management services on CMS 1500 and/or UB04 forms. The information in this policy serves as a reference resource for the E/M Services described and is not intended to be all inclusive.

Claim submissions coded with the correct combination of procedure code(s) is critical to minimizing delays in claim(s) processing. Professional claims submissions should contain all appropriate codes related to the services rendered.

Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

Descriptions/Terms

Established Patient – A member who has received professional services from the physician or other Qualified Healthcare Professional or another physician or other Qualified Healthcare Professional of the exact same specialty and subspeciality who belong to the same group practice, within the last three years.

New Patient – A member who has not received any professional services from the physician or other Qualified Healthcare Professional or another physician or other QHP of the exact same specialty and subspecialty who belong to the same group practice, within the last three years.

Qualified Healthcare 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 their scope of practice and independently reports that professional service.

Reimbursement Information

The member's medical record documentation of services that were rendered by the provider must indicate the presenting symptoms, diagnoses and treatment plan, and a written order by the provider (when applicable). All contents of medical records should be clearly documented, including but not limited to clinical notes, consultation notes, lab testing, pathology testing and radiology testing.

Medical records and itemized bills may be requested from the provider for review to validate the site of service, level of care rendered, and services billed were accurately reported. Medical records may be reviewed to determine the extent of history, extent of examination performed, complexity of medical decision making/MDM, and services rendered. This information, in conjunction with the level of services billed for the level of care rendered, may be reviewed, and evaluated to determine if the level of service was appropriately billed.

Evaluation and Management Coding and Billing

Refer to the most current version of the American Medical Association CPT book for a current list of E/M codes with detailed information, such as time parameters. CPT/HCPCS codes and modifiers mentioned in this policy may be subject for review before payment can be made.

Professional- Levels of E/M Services

E/M codes that have levels of services include a medically appropriate history and/or physical examination when performed on the date of the encounter. However, the extent of history and/or physical examination is not a component in the selection of the level of E/M service. Providers must select the appropriate level of E/M services based on 1) the level of MDM, or 2) the total time for the E/M services performed on the date of the encounter. Documentation must include a medically appropriate history and physical exam.

For additional information that is not captured below, refer additional plan documents, CMS, and AMA published documentation for evaluation and management services.

Medical Decision Making is documented by the complexity of establishing a diagnosis, assessing the status of a condition, and/or selecting a management option, which is determined by considering these factors:

- The number and complexity of problem(s) addressed during the encounter.
- The amount and/or complexity of data, such as but not limited to, medical records, diagnostic tests, notes, reports, or other information, that must be obtained, reviewed, and analyzed.
- The risk of complications and/or morbidity or mortality of patient management.

The table below shows the types of medical decision making, number of diagnosis or management options, amount and/or complexity of data to be reviewed and the risk of significant complications, morbidity, or mortality. To qualify for a specific type of medical decision making, two of the three elements must either be met or exceeded.

Type of Medical Decision Making:	Straight Forward	Low Complexity	Moderate Complexity	High Complexity
1. Number and Complexity of Problems Addressed at the Encounter	**Minimal** 1 self-limited or minor problem.	**Low** • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury; or • 1 stable, acute illness; or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Moderate** • 1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment; or • 2 or more stable, chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute, complicated injury	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function
2. Amount and/or Complexity of Data to be Reviewed	**Minimal or None**	**Limited**	**Moderate**	**Extensive**
3. Risk of Significant Complications, Morbidity,	**Minimal** risk of morbidity from additional	**Low** risk of morbidity from additional	**Moderate** risk of morbidity from additional diagnostic	**High** risk of morbidity from additional diagnostic

and/or Mortality	diagnostic testing or treatment	diagnostic testing or treatment	testing or treatment	testing or treatment

Note, Level of MDM does not apply to CPT codes 99211 and 99281.

Split or Shared Visits

Split or shared visits is a visit in which a physician and other QHP both provide the face-to-face and non-face-to-face work related to the visit. When time is used to select the appropriate level of services for when time-based reporting of a shared or split visit is allowed, the time that is personally spent by the physician or other QHP on the date of the encounter is combined to define the total time. Only distinct time should be combined for shared or split visits. If prolonged time occurs, providers should submit the appropriate prolonged service(s) code. The total time on the date of the encounter spent caring for the member should be documented when it is being used as the basis for code selection.

Include modifier **-FS** on claims to identify a split or shared visit. Additionally, documentation must identify the two providers who performed the visit and include a date and signature by the provider who provided the substantive portion.

Critical Care codes **99291** and **99292** are reviewed using the criteria listed in the American Medical Association, CPT Codebook:

- **99291** Critical Care First Hour: First 30-74 minutes of critical care. There is a 30-minute time requirement for billing of critical care. The administration and monitoring of IV vasoactive medications (such as adenosine, dopamine, labetalol, metoprolol, nitroglycerin, norepinephrine, sodium nitroprusside, continuous infusion (drips), etc. is indicative of critical care.
- **99292** Additional 30 minutes: CPT 99291 plus additional 30-minute increments (beyond the first 74 minutes). Medical records must document the total critical care time.

Chronic Care Management Services CPT Codes 99490 and 99491

Chronic Care Management codes may only be reported by the single physician or other QHP who provides the care management role with the member for the calendar month. CCM services are management and support services that are provided by clinical staff, under the direction of a physician or other QHP, or may be provided personally by a physician or other QHP to a member that is residing in a home or in a domiciliary, rest home, or assisted living facility. These services are provided when a medical and/or psychosocial need of the member require establishing, implementing, revising, or monitoring the care plan. For a complete list of care management activities that are performed by the clinical staff, or personally

by the physician or other QHP, providers should review the most current version of the CPT Codebook. Additionally, providers should review the CPT Codebook for a complete list of codes that should not be reported in the same calendar month, or for service time reported with CCM service CPT codes.

99490- Report for first 20 minutes of clinical staff time directed by a physician or other QHP for time spent on care management activities per calendar month with the following required elements:

- There must be 2 or more chronic conditions expected to last at least 12 months, or until death of patient,
- Chronic conditions that place the patient at a significant risk of death, functional decline, or acute exacerbation/decompensation,
- Comprehensive care plan is established, implemented, revised, or monitored.

This code may only be reported one time during the calendar month.

Services less than 20 minutes, in a calendar month, are not reported separately. The physician or other QHP may report E/M services for specific problems treated or managed in accordance with the CPT level of care.

99491- Report for first 30 minutes of time spent personally by the physician or other QHP for chronic care management services, per calendar month with the following required elements:

- There must be 2 or more chronic conditions expected to last at least 12 months, or until death of patient,
- Chronic conditions that place the patient at a significant risk of death, functional decline, or acute exacerbation/decompensation,
- Comprehensive care plan is established, implemented, revised, or monitored.

This code may only be reported one time during the calendar month.

Office or Other Outpatient Services CPT Codes 99202-99205 (New Patient), and 99212-99215 (Established Patient) [1]

The E/M office or other outpatient services CPT codes, (99202-99205, 99212-99215) do **not** require documentation of the extent of history or the extent of examination performed components for eligible reimbursement. The plan will accept the following:

1. The level of the medical decision making as defined for each service;

OR

2. The total time for E/M services performed on the date of the encounter. (See time chart below)

Example: Level of Medical Decision Making (1)

Type of Medical Decision Making:	**Straight Forward**
CPT Code(s)	**99202**- Office O/P NEW SF 15-29 MIN **99212**- Office O/P EST SF 10-19 MIN
Number and Complexity of Problems Addressed at the Encounter	**Minimal** 1 self-limited or minor problem.
Amount and/or Complexity of Data to be Reviewed	**Minimal or None**
Risk of Significant Complications, Morbidity, and/or Mortality	**Minimal** risk of morbidity from additional diagnostic testing or treatment

Type of Medical Decision Making:	**Low Complexity**
CPT Code(s)	**99203**- Office O/P NEW LOW 30-44 MIN **99213**- Office O/P EST LOW 20-29 MIN
Number of Complexity of Problems Addressed at the Encounter	**Low** • 2 or more self-limited or minor problems; **or** • 1 stable chronic illness; **or** • 1 acute, uncomplicated illness or injury; **or** • 1 stable, acute illness; **or** • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
Amount and/or Complexity of Data to be Reviewed	**Limited** Must meet criteria[1]

Risk of Significant Complications, Morbidity, and/or Mortality	**Low** risk of morbidity from additional diagnostic testing or treatment

Type of Medical Decision Making:	**Moderate Complexity**
CPT Code(s)	**99204**- Office O/P NEW MOD 45-59 MIN **99214**- Office O/P EST MOD 30-39 MIN
Number of Complexity of Problems Addressed at the Encounter	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • 2 or more stable chronic illnesses; **or** • 1 undiagnosed new problem with uncertain prognosis; **or** • 1 acute illness with systemic symptoms; **or** • 1 acute complicated injury
Amount and/or Complexity of Data to be Reviewed	**Moderate** Must meet criteria[1]
Risk of Significant Complications, Morbidity, and/or Mortality	**Moderate** risk of morbidity from additional diagnostic testing or treatment

Type of Medical Decision Making:	**High Complexity**
CPT Code(s)	**99205**- Office O/P NEW HI 60-74 MIN **99215**- Office O/P EST HI 40-54 MIN
Number of Complexity of Problems Addressed at the Encounter	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • 1 acute or chronic illness or injury that poses a threat to life or bodily function

Amount and/or Complexity of Data to be Reviewed	**Extensive** Must meet criteria[1]
Risk of Significant Complications, Morbidity, and/or Mortality	**High** risk of morbidity from additional diagnostic testing or treatment

Example: Total time spent on the date of the encounter (2)-Time is calculated by the total time on the date of the encounter including both face-to-face and non-face-to-face time personally spent by the physician or other QHP. It does not include any of the time spent in the performance of other separately reported services that were rendered. When time is used for reporting E/M services, the time is included in the code descriptors. Documentation should support the time for each code billed.

CPT Code (New)	Time	CPT Code (Established)	Time
99202	15-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99213	20-29 minutes
99204	45-59 minutes	99214	30-39 minutes
99205	60-74 minutes	99215	40-54 minutes

Note, time is not a descriptive component for the emergency department levels of E/M services as they are typically provided on a variable intensity basis that may involve multiple encounters with several patients over an extended period of time.

CPT Code 99211-Office or Other Outpatient Services (Established Patient)

CPT code 99211 is reported if the physician or other QHP's time is spent in the supervision of clinical staff who perform face-to-face services in the office or other outpatient office setting. CPT code 99211 is used for a basic service encounter (short office visit) with an established patient, that may not require the presence of the physician or QHP.

Prolonged Service(s) CPT Codes 99358, +99359, +99415, +99416, +99417, +99418

Prolonged Service on Date Other Than the Face-to-Face E/M Service Without Direct Patient Contact- Physicians and other QHPs may bill CPT codes 99358 and the add-on code +99359 when billing for prolonged services rendered on a date other than the date of a face-to-face evaluation and management encounter with

the member and/or family/caregiver. These codes may be billed for prolonged services in relation to any evaluation and management service on a date other than the face-to-face service, regardless of whether time was used to select the level of face-to-face service. These codes may be billed for the total duration of the non-face-to-face time by the physician or other QHP even if the time spent by the physician or other QHP is not continuous.

Prolonged Clinical Staff Services with Physician or Other QHP Supervision- CPT add-on codes +99415 and +99416 may be billed to report a prolonged E/M service that was provided in the office or outpatient setting for prolonged clinical staff face-to-face time with the member and/or family/caregiver. A physician or other QHP must be present to provide direct supervision of clinical staff. These codes are reported in addition to the designated E/M services and/or any other services provided during the same session as E/M services. These codes are utilized to report the total duration of face-to-face time spent by the clinical staff on a given date, even if the time is not continuous. Note, time spent on separately reported services other than the E/M service should not be counted toward the prolonged service times.

Prolonged Service with or Without Direct Patient Contact on the Date of an E/M Service- CPT code +99417 is an add-on code that is used to report the prolonged total time that is provided by a physician or other QHP on the date of the office or other outpatient services, or other outpatient E/M service(s). CPT code +99418 is an add-on code that is used to report the prolonged total time that is provided by the physician or other QHP on the date of an inpatient E/M service. Note, prolonged total time is time that is at least 15 minutes beyond the time that is required to report the highest-level primary service. Documentation should support the time for each code billed. Services rendered less than 15 minutes should **not** be billed using +99417 or +99418. Additional guidance when reporting CPT codes +99417 and +99418 can be found in the most current edition of the AMA CPT Codebook.

Note, CPT code +99417 and HCPCS code G2212 cannot be submitted at the same time. Additionally, Industry guidelines state when billing Medicare for services described in G2212/+99417, providers should use G2212 instead of +99417**.** For non-Medicare billing, the plan will accept either code G2212 or 99417 when billed appropriately.

Note, time spent rendering separately billed service(s) other than the E/M or psychotherapy service(s) is not counted toward the prolonged service time.

99358- PROLONG SERVICE W/O CONTACT (Used to bill the first hour of prolonged E/M service before and/or after direct patient care. This code should not be billed on the same date of service as 99202-99205/99212-99215

and other.)
+99359- PROLONG SERV W/O CONTACT ADD (Used to report each additional 30-mintues beyond the first hour or to report the final 15-30 minutes of prolonged service on a given date. This code should be billed in conjunction with 99358. This code should not be billed on the same date of service as 99202-99205/99212-99215 and other.)
+99415- PROLNG CLIN STAFF SVC 1ST HR (Used to report prolonged clinical staff time beyond the typical service time during the E/M service in the office or outpatient setting. This code should be billed in conjunction with 99202-99205/99212-99215. This code should not be billed in conjunction with CPT code 99417.)
+99416- PROLNG CLIN STAFF SVC EA ADD (Used to report each additional 30 minutes for prolonged clinical staff time beyond the typical service time during the E/M service in the office or outpatient setting. This code should be billed in conjunction with CPT code 99415 and should not be billed in conjunction with CPT code 99417.)
+99417- PROLNG OFF/OP E/M EA 15 MIN (Used to bill each additional 15 minutes beyond the total time on the date of the primary E/M service, either with **OR** without direct patient contact. This code should be billed in conjunction with 99205, 99215, 99245, 99345, 99350, and 99483. This code should not be billed on the same date of service as 99415, 99416 and other.)
+99418- PROLNG IP/OBS E/M EA 15 MIN (Used to bill for prolonged inpatient or observation E/M time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using the total time for each 15 minutes of total time. This code should be used in conjunction with 99223, 99233, 99236, 99255, 99306 and 99310. This code should not be billed on the same date of service as 90833, 90836, 90838, 99358, and 99359.)
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 QHP, with or without direct patient contact. This code is not reported for any time unit less than 15 minutes. This code is listed separately in addition to CPT codes 99205, 99215, and 99483 for office or other outpatient E/M services. This code should not be reported on the same date of service as CPT codes 99358, 99359, 99415 or 99416.

Additional Resources

Clinical Payment and Coding Policy

CPCP001 Observation Services Policy

CPCP014 Global Surgical Package- Professional Providers

CPCP029 Medical Record Documentation

References

Department of Health and Human Services Centers for Medicare & Medicaid Services, Evaluation and Management Services Guide: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Healthcare Common Procedure Coding System (HCPCS)

Policy Update History

Approval Date	Description
10/04/2019	New Policy
09/25/2020	Annual Review, Disclaimer update; Verbiage update
12/07/2020	Added new code number
12/23/2021	Annual Review
04/12/2023	Annual Review
12/1/2023	Added verbiage
05/29/2024	Annual Review/Verbiage update
08/07/2024	Effective date change and consultation effective date changed