Reimbursement Policy

Effective Date.....10/19/2019
Reimbursement Policy Number R30

Evaluation and Management Services

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INSTRUCTIONS FOR USE
*Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy Proprietary information of Cigna. Copyright ©2020 Cigna*

Overview

Evaluation and Management (E/M) are services provided by a physician or other qualified healthcare professional. The Current Procedural Terminology (CPT®) describes "professional services" as face to face services that are completed by a physician or other qualified health care professional.

This policy applies to all claims submitted on a CMS 1500, UBO4 and all electronic equivalents claim form.

Reimbursement Policy

Cigna allows reimbursement for an Evaluation and Management (E/M) services when the following criteria are met:

- **Cigna utilizes the CMS 1997 coding documentation guidelines.**
- **Supporting documentation satisfies the key component criteria for the level of the Evaluation and Management service as defined by CMS in the 1997 Documentation Guidelines for Evaluation and Management Service.**

Cigna does not reimburse for:

- **For outpatient or inpatient consult codes.**
- **Professional evaluation and management (E/M) codes when billed by a facility on a UB04 claim form.**
- **CPT code 99211 when billed with modifier 25.**
- **E/M services billed with modifier 25 and joint injection codes billed on the same date of service, with a same or similar diagnosis code are not separately reimbursable without documentation supporting the use of Modifier 25.**

General Background

Evaluation and Management (E/M) are services provided by a physician or other qualified healthcare professional. The Current Procedural Terminology (CPT®) describes "professional services" as face to face services that are completed by a physician or other qualified health care professional.

The current CPT evaluation and management section provides documentation guidelines including the definitions of new and established visits. The Centers Medicare & Medicaid Services (CMS) published 2 sets of documentation guidelines the 1995 and 1997 guidelines. Cigna recognizes and follows the CMS 1997 coding documentation guidelines.

Evaluation and Management codes are identified within the Current Procedural Terminology (CPT®) ranging in various types of services. Some types of service within the section are but not inclusive:

- Office visits - both established and new with descriptions
- Hospital services – inpatient and observation
- Emergency
- Preventive
- Critical Care
- Other codes that are based on location
- The codes contain descriptions and key components: history, examination, and medical decision making which are necessary for code selection.

New and Established Patients:
Cigna follows AMA's definitions of what is considered to be a new or established patients.

New Patient

Cigna follows the guidance in the CPT® and CMS, a new patient is one who has not received professional services by the same physician, or another physician within the same practice (group) within the previous 3 years.

Established Patient

Cigna follows in the CPT® and CMS, an established patient who has received professional services by the same physician, or another physician within the same practice (group) within the previous 3 years.

Consultation Codes:

Consultations services are evaluation and management services that are requested by physician/qualified healthcare professional during the care of a patient to obtain advice, or an opinion of care concerning a specific condition or problem.

Cigna will not reimburse consultation codes 99241 – 99245, and codes 99251 - 99255. Non-consultative Evaluation and Management Codes may be utilized based on the code that best describes the service performed.

Evaluation and Management Codes in the Facility:

Cigna will not reimburse professional evaluation and management (E/M) codes when billed by a facility on a UB04 claim form.

Multiple Patient Encounters on the Same Day

Cigna does not reimburse two E/M service codes submitted for the same date of service unless the presenting situation is one of the exception scenarios noted below. Generally, the service code with the higher Relative Value Unit (RVU) will be considered for reimbursement.* The CMS Medically Unlikely Edit (MUE) of 2 for codes 99212, 99213 and 99214 is excluded from editing as it conflicts with this reimbursement policy indicating that we only pay 1 E/M service per health care professional per single date of service.

One exception to reporting multiple patient encounters in one day is that of prolonged services with direct face-to-face patient contact (CPT® 99354, 99355). When appropriate, these codes may be used in conjunction with another E/M code for the same date of service.

Another exception to multiple patient encounter reporting is submitting a preventive medicine office visit (CPT 99381-99397) with a problem-based office visit (CPT 99201-99215). In some cases reporting both office visits may be appropriate. In these situations append modifier 25 to the E/M code that would otherwise be disallowed* to indicate a significant, separately identifiable E/M service was provided. See the *Preventive Medicine Evaluation and Management Service and Problem Based Evaluation and Management Service on the Same Day* Reimbursement Policy under the related links section at the top of this policy for more information.

Modifiers usage with Evaluation and Management Codes

Modifier 24

Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional during a Postoperative Period

Modifier 24 is used to indicate an unrelated Evaluation and Management (E/M) service that is provided during the postoperative period.

According to the Current Procedural Terminology (CPT®) manual, “the physician may need to indicate that an E/M service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service”.

Modifier 25

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.

The use of modifier 25 requires the three key components (history, examination, and medical decision making) to be documented.

Cigna allows separate reimbursement for an Evaluation and Management (E/M) service or office visit when indicated criteria are met. See also Cigna Modifier 25 CMS/NCCI Documentation Requirement List.

Based on the low complexity of E/M code 99211 and not requiring a physician or other qualified healthcare professional present in the exam room with the patient, Cigna will not reimburse when billed with modifier 25.

Modifier 57

Modifier 57 is appended to the E/M to represent the initial decision for major surgery (global period of 090 days) that will occur either the same day or the next day. It is not appended to E/M services when the surgery is scheduled for a date in the future (e.g. 2 weeks, 3 months).

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

CPT®** Codes	Description
99201 - 99205	Office or other outpatient visit: new patient
99211 – 99215	Office or other outpatient visit: established patient
99218 – 99220	Initial observation care
99221 – 99223	Initial hospital care
99231 – 99233	Subsequent hospital care
99224 – 99226	Subsequent observation care
99234 – 99236	Observation or inpatient care (patient admit and discharge on the same day
99238 - 99239	Hospital discharge day management
99281 – 99285	Emergency department
99304 – 99306	Initial nursing facility care
99307 - 99310	Subsequent nursing facility care
99318	E/M annual nursing facility assessment
99324 – 99328	Domiciliary or rest home visit; new patient
99334 – 99337	Domiciliary or rest home visit; established patient
99341 – 99345	Home visit; new patient
99347 – 99345	Home visit; established

Not Separately Reimbursed inpatient and outpatient E/M consultation Codes:

CPT®* Codes	Description
99241 – 99245	Office/outpatient Consultation; new or established patient
99251 – 99255	Inpatient Consultation; new or established patient

Not Separately Reimbursed: E/M with joint injections

E/M codes 99212, 99213, 99214, 99215 are not be reimbursed without documentation supporting the use of modifier 25 when billed with the following joint injection codes with a same or similar diagnosis code on the same date of service.

CPT®* Codes	Description
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

References

1. American Medical Association. Current Procedural Terminology (CPT®) ©2019 Professional Edition.
2. CMS 1997 Documentation Guidelines for Evaluation and Management Services©
3. Deborah J. Grider, Coding with Modifiers 5th edition (Chicago, IL: American Medical Association, ©2014), 50-70.
4. Optum360, Understanding Modifiers 2020 (USA: Optum360, ©2019), 13-27.

Policy History/Update

Date	Change/Update
05/12/2020	Updated reference section and changed reimbursement to reimburse in the reimbursement policy section.
03/16/2020	Effective date: Evaluation and Management codes 99212 – 99215 appended with modifier 25 will not be reimbursed without documentation supporting when billed with injection codes 20600, 20604, 20605, 20606, 20610, and 20611. Denial of code 99211 when billed with modifier 25. Also added the hospital discharge management codes 99238 – 99239.
02/26/2020	Revised wording for E/M with injection policy statement.
12/17/2019	Notification of Evaluation and Management codes 99212 – 99215 appended with modifier 25 will be denied when billed with injection codes 20600, 20604, 20605, 20606, 20610, and 20611. Denial of code 99211 when billed with modifier 25. Also added the hospital discharge management codes 99238 – 99239.
10/19/2019	Effective Date of denial of Consultation Codes.
07/18/2019	Notification for Consultation Codes not reimbursable effective 10/19/2019