2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services

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Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM076**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** Details below

Reimbursement Guidelines

A. General Statement

The 2021 revisions to the Evaluation and Management (E/M) codes made changes to the office visit and outpatient E/M code definitions, code selection process, and to the prolonged services guidelines. The 2023 E/M revisions expand those changes to all remaining care settings. The changes also impact documentation requirements to support billed E/M procedure code(s).

B. History and Physical Examination

1. The extent of the history and physical examination is no longer used in selecting the E/M level and procedure code; as a result, the code descriptions no longer include references to these aspects of the visit.
2. Yet a medically appropriate history and physical examination is still expected to be performed with every evaluation and management service.
   a. The history and the physical examination is important to document for clinical communication with other current and future medical professionals.
   b. However, the documentation of the history and the physical examination is no longer scrutinized and quantified for purposes of selecting the E/M level and billing procedure code.
3. Reimbursement for the work of the history and physical exam is included in reimbursement for the E/M procedure code.

C. Levels of E/M Services

1. Within each category or subcategory of E/M service there are three to five (usually four) levels of E/M services to report. In some categories the lowest level visit codes have been deleted because the Medical Decision Making (MDM) was the same as for the next code (which is retained).
2. "Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient." [22]
3. When the practitioner's scope of license includes evaluation and management services, each and any level of E/M services may be used by all physicians or other qualified health care professionals.[22]

D. Selecting the Appropriate Level of E/M Service

1. For all categories other than the Emergency Department, the appropriate level of E/M services may be selected based on the provider's choice of either of the following (note: exception for psychotherapy with E/M):
   a. The level of MDM, as defined for each service.
   b. The total time for E/M services performed on the date of the encounter. When using Time:
      i. The level of medical decision-making is not considered.
      ii. Total time on the date of the encounter is used.
         1) Total time includes both face-to-face and non-face-to-face time, as long as it is personally spent by the physician or other qualified health care professional.
         2) Time spent on the previous date or any date following the encounter (e.g., after midnight) is not included in the Total Time.
         3) Time spent by clinical staff is not included.

2. Exception to rule # 1 above:
   Time may not be used to select E/M code when psychotherapy services are performed with E/M services; the E/M service must be coded based upon medical decision making.[38, 39]
   a. The psychotherapy services are reported with specific time-based procedure codes (90833, 90836, 90838) which are add-on codes to the E/M service procedure code.
      i. The separate time for the psychotherapy needs to be documented
      ii. The time spent performing the E/M service cannot be counted in the time for the psychotherapy service. Thus, the time documented for the psychotherapy services must be less than the total amount of time spent with the patient.
   b. Prolonged services may not be reported. [38]

3. The AMA has provided detailed instructions in the E/M guidelines for both methods (MDM and Time) of determining the E/M level.
   a. Tables are included.
   b. Some specific examples are included.
   c. Further information and details, additional criteria for Data Reviewed and examples of Risk of Complications/Morbidity/Mortality are available from the AMA.[3, 4, 11]

4. The medical record documentation must support the criteria for whichever method of level selection is used.
   a. Medical records do not need to be sent with the claims for E/M codes. Should Moda need to request medical records, be sure they are returned to Moda within 30 days from the date of our request.
   b. When medical records are reviewed, Moda Health will accept documentation of the following to support the billed level of service:
      i. The level of the medical decision making (MDM) for each service;
      Medical decision making is documented by the complexity of establishing the diagnosis and/or management options that are measured by:
         1) The number of possible diagnosis and/or number of management options to be considered;
         2) The amount and/or complexity of medical records, diagnostic tests, notes, reports or other information that must be obtained and reviewed and analyzed;
         3) The risk of significant complications, morbidity and/or mortality, as well as comorbidities that are associated with the member's presenting problems, diagnostic procedures and/or possible management options.

- OR -

ii. The total time for E/M services performed on the date of the encounter.
   1) Document time with begin-time and end-time.
   2) If E/M service time is not continuous then multiple begin-time and end-times with type of activity may need to be documented in the medical record.
   3) Refer to the CPT guidelines and various CPT Assistant articles for the various activities that qualify and don't qualify for calculating the total time on the day of the encounter.[2]

5. Additional resources are available from the AMA, CMS, and the local Medicare Administrative Contractor (MAC):
   a. Webinar on 2023 E/M Changes. [24]
   b. Multiple videos, tools, FAQs, and a Simplified Outpatient Documentation & Coding Toolkit are available at the AMA's page on "Implementing CPT® Evaluation and Management (E/M) revisions." [28]
   c. Published CPT Assistant articles. [1, 2, 3, 4, 5, 6, 7, 8, 9, 21, 26, 27]
   d. Additional articles & documents on the AMA website. [10, 11, 12, 22, 23, 24, 28]
   e. "Medicare Physician Fee Schedule Final Rule Summary: CY 2023." MLN Matters Number: MM12982.[33]
   f. Noridian Medicare webinar on "2023 Evaluation and Management Updates," offered on December 8, 2022, December 21, 2022, January 10, 2023, and January 26, 2023.
   (Noridian indicated the December 8, 2022 session was being recorded; as of this update a link is not found but it may later be posted on-demand listening.)

E. Prolonged Services Changes and Code Sets

1. Prolonged services can now only be billed in combination with the highest level of E/M in each category (setting grouping).

   This is because prolonged services is a time-based service, and the level of E/M service/procedure code can now be selected based upon Time. Extended time (prolonged service) can only be billed in addition to the procedure code for the maximum amount of time.

2. The list of acceptable primary procedure codes for 99417 have changed with the 2023 revisions. These guidelines are listed within parentheses directly below the code description.
   a. Four procedure codes have been added as acceptable primary procedure codes.
   b. Three procedure codes have been removed from the list of acceptable primary procedure codes and added to a second parenthetical list of codes which may not be reported on the same day as 99417.

3. Neither 99417 nor 99418 may be reported with psychotherapy procedure codes; no prolonged services procedure code is available for this situation.
   a. Dr. Peter Hollmann, Co-Chair of the CPT/RUC Workgroup on E/M, explained the psychotherapy participants in the E/M Revision workgroup indicated a prolonged service code is not needed for psychotherapy services. [25]
   b. Should providers disagree with this decision, they will need to work directly with their professional specialty society/association to have a request submitted to the AMA for a new procedure code to be created for this purpose.

4. Two separate and competing sets of prolonged services procedure codes to use (AMA & CMS).
   a. The AMA and CMS have each created different/separate prolonged services procedure codes and guidelines.
      i. The code descriptions for the AMA code 99417 and 99418 and the corresponding CMS codes G2212, G0316, G0317, and G0318 are very similar, but with subtle differences.
      ii. The guidelines for time required to report these codes also have subtle differences.

b. Reason:
   i. The RVU for each E/M procedure code includes approximately 15 minutes of additional provider time beyond the time specified in each E/M code description.
      1) Yet the AMA prolonged services codes may be reported for the first full 15 minutes beyond the time specified in the E/M code descriptions.
      2) Because of this, CMS indicates that if the AMA prolonged services procedure codes and guidelines are used, the first 15 minutes of prolonged services will be paid twice, once under the primary E/M procedure code, and a second time under the first unit of the prolonged services procedure code.
   ii. CMS also strongly prefers prolonged services codes for specific care settings to enable better data collection from claims procedure codes alone.
   iii. CMS has outlined additional concerns related to the AMA prolonged services codes and guidelines. [30, 31]

c. Due to the above reasons, CMS will not accept the AMA prolonged services codes and considers them invalid for Medicare. Instead, CMS created G2212, G0316, G0317, and G0318 for prolonged services with specific guidelines.

F. Prolonged Services Reimbursement & Processing

Because our fee schedules use CMS fee schedule methodology, including RVUs and the double-payment concerns noted above, we will process prolonged services as follows:

1. Commercial and Medicare Advantage plans:
   a. CPT codes 99417 and 99418 are not accepted for processing for Commercial or Medicare Advantage plans. Instead, use G2212, G0316, G0317, and G0318.
   b. CPT codes 99417 and 99418 will be denied with one of the following:

      Denial explanation code:

53B	This procedure code is not accepted for processing by Moda Health for this type of plan and/or line of business.
u14	This procedure code is not accepted for processing for this type of plan and/or line of business.

      835 CARC/RARC denial combination:

CARC 16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
RARC N657	This should be billed with the appropriate code for these services.

2. Medicaid plans:
   a. 2021 E/M changes:
      i. Procedure code G2212 was initially not listed on the OHA fee schedule and so 99417 was accepted for prolonged E/M services.
      ii. G2212 was later added to the OHA fee schedule and became the Medicaid procedure code for prolonged office visit or outpatient E/M services.
   b. 2023 E/M changes:
      i. CPT codes 99417 & 99418 will be accepted for prolonged services until such time as the OHA fee schedule lists fees for G0316, G0317, and G0318 and they are included for OHA coverage on the prioritized list or under ancillary coverage provisions.
      ii. If no OHA fee is listed for 99418, then the CMS RVUs for G0316, G0317, and/or G0318 will be used to follow the DMAP MPA calculations to establish an allowance for 99418.

G. Determining Specialty For Non-Physician Practitioners (NPP)

1. The CMS and CPT guidelines differ for determining specialty for non-physician practitioners (NPP).
   a. CMS: "…classifies NPPs in a specialty that is not the same as a physician with whom the NPP is working…" [18]
   b. AMA/CPT: "When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician." [19]

2. We follow the AMA/CPT guidelines for NPP specialty determination.
   Thus, when advanced practice nurses and physician assistants are working with a group of physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physicians with which they work. This may impact clinical editing based on same-specialty.

H. Shared or split visits

1. A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) (e.g., PA, NP, CNS, etc.) jointly provide the face-to-face and non-face-to-face work related to the visit.
   a. Per CMS, "Split (or shared) visits are furnished only in the facility setting…" [17]
   b. Only one of the providers may submit a claim for the joint split/shared visit.
   c. The claim for the visit is submitted by the provider who performed the substantive portion of the visit.

2. When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time.
   a. Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted). [11]
   b. Examples:
      i. The PA sees an established patient in the exam room for 20 minutes, then the MD joints the PA in the exam room and they both see the patient together for 12 additional minutes. This visit is being coded based upon time rather than MDM.

         This is a 32-minute visit (99214). The 12 minutes when both the PA and the MD were in the room with the patient can only be counted once, not once per each provider present in the room.
      ii. The NP sees an established patient in the exam room for 25 minutes, then the NP leaves to discuss the patient with the MD for 5 minutes. Then the MD sees the patient for an additional 20 minutes. At the end of office hours, the MD and the NP meet for another 15 minutes to discuss the case and jointly develop the long-term treatment plan. This visit is being coded based upon time rather than MDM.

         This is a 65-minute visit (99215). The 5 minutes spent discussing the patient between the switch from NP to MD and the 15 minutes of joint care and treatment planning at the end of the workday can only be counted once. This time cannot be counted as 20 minutes for the NP and also 20 minutes for the MD (that would be considered double-counting or double-dipping).

3. Requirements for CPT code 99211
   a. The code definition for 99211 describes a visit for "…an established patient, that may not require the presence of a physician or other qualified health care professional..." and does not have a time frame defined.
   b. CPT 99211 does not require a face-to-face encounter with the physician or other qualified health care professional (QHP).

i. The face-to-face service may be provided by clinical staff.
ii. The physician or other QHP who bills CPT 99211 must spend time supervising the clinical staff in order to report 99211. (See "direct supervision" and "immediately available" in the Definition of Terms Table section of this policy.)

I. New Patient Versus Established Patient E/M Codes

1. The amount of time required for billing a new patient visit code is different than the amount of time required for billing an established patient visit code for corresponding level E/M codes. Please reference the time frames listed in the procedure code descriptions.

2. For guidelines regarding whether to select a new patient visit code or an established patient visit code, refer to the following sources:
   a. CPT book guidelines for the date of service in question, Evaluation and Management (E/M) Services Guidelines, New and Established Patient subsection. [34]
   b. Evaluation and Management Services Guide Booklet [35]
   c. New Patient vs Established Patient Visit [36]
   d. New vs Established Patient Decision Tree Flowchart [37]

Definitions

Acronyms/Abbreviations

Acronym	Definition
AHA	American Hospital Association
AMA	American Medical Association
APP	Advanced Practice Provider
ASO	Administrative Services Only
CARC	Claim Adjustment Reason Code
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CNS	Clinical Nurse Specialist
CPT	Current Procedural Terminology
ED	Emergency Department (also known as/see also ER)
E/M E&M E & M	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
EOB	Explanation of Benefits
EOP	Explanation of Payment (formerly called PDR Payment Disbursement Register)
ER	Emergency Room (also known as/see also ED)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MDM	Medical Decision Making
MPFS MPFSD MPFSDB	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MUE	Medically Unlikely Edits
NCCI	National Correct Coding Initiative (aka "CCI")
NP	Nurse Practitioner

Acronym	Definition
NPP	Non-Physician Practitioners
PA	Physician Assistant
PDR	Payment Disbursement Register (currently called EOP Explanation of Payment)
PTP	Procedure-To-Procedure (a type of CCI edit)
QHP	Qualified Health Care Professional; Qualified Healthcare Professional
RARC	Remittance Advice Remark Code
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	Relative Value Unit
TOB	Type of Bill
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 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 specified professional service, but does not individually report that professional service. [19]
Direct Supervision	The supervising physician does not need to be present in the room during the procedure but must be immediately available to furnish assistance and direction throughout the procedure's performance. (See also "Immediately Available") In the office setting, the location proximity requires the supervising physician must be present in the office suite.[14, 15, 16] Definition specified at 42 CFR 410.32(b)(3)(ii)
Drug therapy requiring intensive monitoring for toxicity	The monitoring is performed for assessment of adverse effects from the therapeutic agent that have the potential to cause serious morbidity or death. The monitoring is not performed primarily for assessment of therapeutic efficacy. For further details, reference CPT Assistant. [4]
External Note(s)	External note(s) are record(s), communication(s), and/or test result(s) from an external physician/other QHPs facility or health care organization. [4]
General Supervision	The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the [service] and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. [14, 15] Definition specified at 42 Code of Federal (CFR) 410.32(b)(3)(i)

Term	Definition
Immediately Available	The supervising physician must not be performing another procedure that cannot be interrupted and must not be so far away that he or she could not provide timely assistance. [16]
Independent Historian(s)	An independent historian is an individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to the history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. Key to this definition is that the independent historian should provide additional information, and not merely restate information already provided by the patient. [4]
Minimal Problem	A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211). [11]
Morbidity	A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment. [4]
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). [20] 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." [19] Other qualified health care professionals consist of Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Midwives, and Certified Registered Nurse Anesthetists (CRNA).
Personal Supervision	The supervision physician must be in attendance in the room during the performance of the service or procedure. [14, 15] Definition specified at 42 CFR 410.32(b)(3)(iii)
Problem	A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter. [40]

Term	Definition
Problem Addressed	A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional 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. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay. [40]
Shared Visit Split Visit	A visit in which a physician and other qualified healthcare professional(s) (e.g. PA, NP, CNS, etc.) jointly provide the face-to-face and non-face-to-face work related to the visit.[11]
Social Determinants of Health	Economic and social conditions that influence the health of people and communities. For example, food or housing insecurity. [4]
Test	Tests are services that result in imaging, laboratory, psychometric, or physiologic data. The differentiation between single and multiple unique tests is defined in accordance with the CPT code set. When a CPT code representing a clinical laboratory panel is reported (e.g., CPT code 80047, Basic metabolic panel (Calcium, ionized)), it is considered a single test. [4]

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Add-on Codes." Moda Health Reimbursement Policy Manual, RPM025.
C. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.
D. "Clinic Services In the Hospital Outpatient Setting - Commercial." Moda Health Reimbursement Policy Manual, RPM061.

Resources

1. AMA. "E/M Office Visit Revisions for 2021: An Overview." *CPT Assistant,* February 2020:3-6.
2. AMA. "E/M Office or Other Outpatient Visit Revisions for 2021: Time." *CPT Assistant,* March 2020:3-5.
3. AMA. "E/M Office or Other Outpatient Visit Revisions for 2021: MDM Part 1." *CPT Assistant,* May 2020:3-8.
4. AMA. "E/M Office or Other Outpatient Visit Revisions for 2021: MDM Part 2." *CPT Assistant,* June 2020:3-9.
5. AMA. "Prolonged E/M Services Revisions for 2021." *CPT Assistant,* September 2020:3-6.
6. AMA. "Frequently Asked Questions – Evaluation and Management: Office or Other Outpatient Services." *CPT Assistant,* September 2020:14.
7. AMA. "Preparing for E/M 2021 Changes." *CPT Assistant,* November 2020:3-6.

8. AMA. "Frequently Asked Questions – Evaluation and Management: Office or Other Outpatient Services." *CPT Assistant,* November 2020:12.
9. AMA. "Frequently Asked Questions – Evaluation and Management: Prolonged Services." *CPT Assistant,* November 2020:12.
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17. CMS. "Split (or Shared) Visits, Settings of Care." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.18.D.
18. CMS. "Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.4.
19. American Medical Association. "Instructions for Use of the CPT Codebook." *Current Procedural Terminology (CPT) 2023, Professional Edition.* Chicago: AMA Press, p. xiv.
20. CMS. "Glossary and Acronyms." Medicare and Medicaid Services. Last accessed July 27, 2022. https://www.cms.gov/OpenPayments/Glossary-and-Acronyms#non-physician-practitioner-covered-recipient .
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32. CMS. "CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Final rule and interim final rules." 42 CFR Parts 405, 410, 411, 414, 415, 423, 424, 425, and 455. Pages 580 - 590/2953. https://public-inspection.federalregister.gov/2022-23873.pdf .
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Policy History

Reminder: 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 current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
2/12/2025	Related Policies updated. Formatting updates. No policy changes.
4/10/2024	Formatting updates. No policy changes.
2/14/2024	Definition of Terms and Resources updated. No policy changes.
6/14/2023	Clarified coding & documentation of E/M services combined with psychotherapy. Coding Guidelines and Resources updated. No policy changes.
12/14/2022	Idaho added to Scope. Title change & major revision to incorporate 2023 E/M changes. Clarified determining specialty for non-Physician practitioners (NPP). Acronyms, Definition of Terms, and Resources updated. No policy changes.
6/8/2022	Clarified new patient vs. established patient visit times & guidelines. Acronyms updated. Formatting updates. No policy changes.
12/30/2020	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2021	Original Effective Date (with or without formal documentation). Policy based on joint CPT & CMS changes to E/M coding for outpatient E/M coding effective January 1, 2021.