Scope Of License For Evaluation & Management Codes

Last Updated: 3/12/2025 **Last Reviewed: 3/12/2025** **Originally Effective: 7/29/2018**

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 #: RPM080**

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

As an insurance carrier, one of our responsibilities to our providers, our members, our employer groups, and state and federal regulatory bodies includes confirming that providers are performing services and filing claims appropriately within their scope of practice and fulfilling the requirements of the billed procedure codes.

Our clinical edit system includes edits to ensure procedure codes with specific requirements are reported by appropriate providers. There are edits to address a variety of procedure codes to determine if the billing provider's scope of license does or does not encompass the key responsibilities required for the billed services.

This policy is intended to help clarify the requirements for performing the key responsibilities of an evaluation and management (E/M) service and the types of providers with a scope of license which includes the ability to perform and report E/M procedure codes.

B. Provider Must Be Qualified to Perform Billed Services

While the American Medical Association does not restrict the reporting of any CPT code to any specific licensure or specialty, they do make it clear that: (AMA[2])

1. The reporting provider must be qualified to perform the services represented by the procedure code.[2]
2. Scope of licensure and credentialing vary on a state-by-state and institutional basis.[2]
3. Third party payer guidelines may differ from the AMA's CPT coding guidelines.
   a. Eligibility for payment, as well as coverage policy, is determined by each individual insurer or third-party payer.
   b. Contact the appropriate third-party payer(s) for coverage and payment policies.[5, 6]

C. Evaluation and Management (E/M) Services

1. The evaluation and management section of the CPT book consists of procedure codes 99202 – 99499. These codes are divided into broad categories and subcategories. Each category may have specific guidelines, or the code descriptions may include specific details.[1]
2. Other evaluation and management procedure codes for specific situations (such as ophthalmological services, psychiatric diagnostic evaluation, etc.) are also available in other sections of the code sets.
3. An evaluation and management service from the evaluation & management section of the CPT book requires that a provider be qualified to perform Medical Decision Making.

4. Components of Medical Decision Making.
   Here is a summary of the major activities and elements of medical decision making gathered from multiple CPT Assistant articles issued and other resources posted by the AMA related to the 2021 and 2023 E/M code revisions and updated E/M guidelines: [5, 6, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20]
   a. Evaluation –
      Assessing and addressing a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter, by means of: [15]
      i. Review of history.
      ii. Examination.
      iii. Consulting independent historians (e.g., parent, guardian, spouse).
      iv. Ordering diagnostic studies (lab tests, radiology studies, etc.).
   b. Management – [15]
      i. Establishing & assigning a diagnosis.
         Per ICD-10-CM guidelines, if a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report diagnosis codes for sign(s) and/or symptom(s).[21, 22]
      ii. Developing a treatment plan.
      iii. Managing risk of complications, morbidity, mortality.
      iv. Discussing findings, prognosis, and treatment options with patient.
      v. Providing counseling regarding condition, treatment, or prevention measures as needed or appropriate.
      vi. Ordering treatment(s) and/or prescriptions. Includes possible decision for surgery.
      vii. Writing referrals.

5. Providers who report E/M procedure codes (99202 – 99499) must have a scope of license which allows them to fully perform medical decision making. Among other things, the provider's scope of license must include the ability to diagnose conditions, write orders for diagnostic tests to be performed, and prescribe (write orders for) medications and treatments.

D. Provider Types Qualified to Report E/M Services

The scope of practice of the following types of providers includes the key responsibilities of medical decision making, or there are specific guidelines from the cited national sources which authorize them to report E/M procedure codes under specific circumstances.

1. Physicians
   a. Medical Doctor (MD)
   b. Doctor of Chiropractic (DC), (taxonomy 111N00000X - 111NT0100X)
   c. Doctor of Osteopathic Medicine (DO)
   d. Doctor of Naturopathy (ND)
   e. Doctor of Naturopathic Medicine (NMD)
   f. Oral Surgeon (taxonomy 1223S0112X)
   g. Psychiatrist (taxonomy 2084P0800X)

2. Physician Assistant (PA)

3. Advanced practice nurses:
   a. Nurse Practitioner (NP)
   b. Clinical Nurse Specialist (CNS)
   c. Certified Nurse Midwife (CNM)
   d. Certified Professional Midwife (CPM)
   e. Certified Registered Nurse Anesthetist (CRNA) [23, 24]

4. Pharmacist (R.Ph., D.Ph., Pharm.D.) for the following member plans only:
   a. Oregon Medicaid plans.[28]
   b. Oregon Commercial plans.[29]

E. Provider Types Not Qualified to Report E/M Services

The scope of practice of the following types of providers does not include medical decision making, so these providers are not eligible to report evaluation and management procedure codes. (This list includes examples which have generated provider inquiries but is not necessarily exhaustive.)

1. Dentists (DDS, DMD)
   a. Based upon statements from Noridian and CMS, only dentists who are also oral surgeons may bill E/M procedure codes.[25, 26, 27]
   b. A provider education letter was mailed to Dental for Medical providers on February 21, 2024. A copy of this letter is included as an Attachment.
2. Registered Nurse (RN, not advanced practice)
3. Behavioral/mental health providers, any and all who are not a Psychiatrist (MD), a Nurse Practitioner (NP), or a Clinical Nurse Specialist (CNS); this includes but is not limited to:
   a. Psychologist (Psy.D.)
   b. Licensed Clinical Professional Counselor (LCPC)
   c. Licensed Clinical Mental Health Counselor (LCMHC)
   d. Licensed Clinical Social Worker (LCSW)
   e. Licensed Mental Health Counselor (LMHC)
   f. Licensed Mental Health Practitioner (LMHP)
   g. Licensed Professional Counselor (LPC)
   h. Licensed Professional Clinical Counselor of Mental Health (LPCC)
   i. Marriage and Family Therapist (MFT)
   j. Supervised behavioral health providers [E]
4. Lactation specialists, counselors, and consultants (BFC, CBC, CLC, CLE, LC, IBCLC, etc.)
5. Dieticians (RD)
6. Physical Therapist (PT)
7. Occupational Therapist (OT)
8. Massage Therapist (MT), Licensed Massage Therapist (LMT), (CAMTC), etc.
9. Pharmacist (R.Ph., D.Ph., Pharm.D.) outside the State of Oregon
10. Clinic
    In general, providers listing clinic taxonomies are not eligible to report E/M services. E/M procedure codes need to be submitted under the individual provider performing the service so that their taxonomy (and thus scope of license) can be evaluated during claim adjudication.

F. Clinical Edits

1. Our system includes clinical edits which evaluate whether or not the billing provider type is appropriate for the procedure code submitted.
   a. The clinical edits for provider type appropriate for procedure code address a variety of procedure codes, including anesthesia, maternity delivery, professional and technical components, E/M services, home infusion, audiology, and more.
   b. This policy focuses specifically on this editing for E/M services.

c. These clinical edits utilize the provider taxonomy in our provider record.
   i. The taxonomy code listed in our provider records is collected from or validated against the National Plan and Provider Enumeration System (NPPES).
   ii. Any provider who holds a dual specialty or dual licensure (e.g., dentist and oral surgeon, or Registered Nurse and Nurse Practitioner) is advised to select the taxonomy of their highest license or specialty as their primary taxonomy in NPPES, as this will be used to validate your provider record and process your claims.

2. Line items which trigger these clinical edits will deny to provider liability with one of the following denial codes:

u08	This provider type/provider specialty may not bill this service.
z03	This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider.

835 CARC/RARC denial combinations:

CARC 170	Payment is denied when performed/billed by this type of provider.
RARC N95	This provider type/provider specialty may not bill this service.

CARC 8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
RARC none	n/a

G. Steps to Remedy Denials for Provider Type Inconsistent With Procedure

If you receive a denial which indicates your provider type is inconsistent with the billed service, the following steps may be taken to remedy the denial.

1. Carefully review this policy in its entirety.
2. If you are one of the provider types qualified to report E/M services, then:
   a. Confirm your taxonomy code listed in the NPPES system is correct.
   b. If you hold a dual licensure, confirm that your highest licensure is listed in NPPES as your primary taxonomy.
   c. Contact your provider representative at Moda to request that your provider record be updated to be consistent with your taxonomy listed in NPPES and request that denied claims are reprocessed when the record update is completed.
3. If you are one of the provider types not qualified to report E/M services, a corrected claim will need to be submitted.
   a. Replace the E/M procedure code with the appropriate procedure code to report the services provided.
   b. In most instances, clinics will need to submit the services under the individual provider performing the E/M service rather than under the general clinic entity.

c. For Dentists providing services related to oral sleep apnea devices, please refer to RPM055 "E0485, E0486 Oral Sleep Apnea Device/Appliance Documentation & Bundled Services." For all other Dentist services, see above.

H. Procedure Codes Available to Provider Types Not Qualified to Report E/M Services

1. We will accept the procedure codes listed in the table below from provider types not qualified to report E/M services.
   a. This is not intended to be a comprehensive list of all possible procedure codes for provider types not qualified to report E/M codes.
   b. Not all of these procedure codes will be appropriate for all types of providers or certifications.
   c. You are responsible for selecting the most accurate and appropriate procedure code to report the services you provide, and for accurately documenting your services. The medical record must support the procedure code(s) reported. [C]
2. The submitting provider's licensure, certification, and training is expected to qualify them to address or counsel patients on the topics addressed (e.g., smoking cessation, diabetes, cancer, lactation needs, etc.).
3. The member's plan benefits and exclusions also apply.

Procedure codes accepted from providers not qualified to report E/M codes (not all-inclusive)	
Code	**Code Description**
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96158*	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159*	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96160*	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161*	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
96164*	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165*	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167*	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168*	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96170*	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
96171*	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients

Procedure codes accepted from providers not qualified to report E/M codes (not all-inclusive)	
Code	**Code Description**
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)
G0444	Annual depression screening, 5 to 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
S3005	Performance measurement, evaluation of patient self-assessment, depression
S9443	Lactation classes, nonphysician provider, per session
S9445	Patient education, not otherwise classified, nonphysician provider, individual, per session
S9452	Nutrition classes, nonphysician provider, per session
S9453	Smoking cessation classes, nonphysician provider, per session
S9454	Stress management classes, nonphysician provider, per session
S9455	Diabetic management program, group session
S9460	Diabetic management program, nurse visit
S9465	Diabetic management program, dietitian visit
S9470	Nutritional counseling, dietitian visit

*Note:
Health behavior assessment and intervention (HBAI) services (96156 - 96171) do not represent a behavioral health service. Instead, the patient's primary diagnosis is physical in nature and the focus of the assessment and intervention is on identifying and addressing the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems.[31]

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
APP	Advanced practice provider (non-Medicare term)
BFC	Breastfeeding Counselor
CAMTC	California Massage Therapy Council (certification)
CBC	Certified Breastfeeding Counselor
CLC	Certified Lactation Counselor
CLE	Certified Lactation Educator
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CNS	Clinical Nurse Specialist
CPM	Certified Professional Midwife
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist

Acronym	Definition
DDS	Doctor of Dental Surgery
DMD	Doctor of Dental Medicine, Doctor of Medicine in Dentistry
DO	Doctor of Osteopathic Medicine
D.Ph.	Doctor of Pharmacy
HBAI	Health Behavior Assessment And Intervention services
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
IBCLC	International Board Certified Lactation Consultant
LC	Lactation Counselor
LCMHC	Licensed Clinical Mental Health Counselor
LCPC	Licensed Clinical Professional Counselor
LMHC	Licensed Mental Health Counselor
LMHP	Licensed Mental Health Practitioner
LMT	Licensed Massage Therapist
LPC	Licensed Professional Counselor
LPCC	Licensed Professional Clinical Counselor of Mental Health
MD	Medical Doctor
MDM	Medical Decision Making
MFCC	Marriage, Family, and Child Counselor
MFT	Marriage and Family Therapist
MT	Massage Therapist
NCHS	National Center for Health Statistics
ND	Doctor of Naturopathy
NMD	Doctor of Naturopathic Medicine
NP	Nurse Practitioner
NPP	Non-physician Practitioner (Medicare terminology)
NPPES	National Plan and Provider Enumeration System
OT	Occupational Therapist
PA	Physician Assistant
Pharm.D.	Doctor of Pharmacy
Psy.D	Psychologist
PT	Physical Therapist
QHCP	Qualified Health Care Professional
RD	Registered Dietician
R.PH.	Registered Pharmacist
RPM	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)

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 clinical staff member is 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 professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.[7, 8, 9]
Medical Decision Making (MDM)	MDM refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the following elements: • The number and complexity of problems addressed at the encounter. • The number of possible diagnoses and/or the number of management options that must be considered. • The amount and/or complexity of data to be reviewed and analyzed. The risk of significant complications, morbidity, and/or mortality of patient management.[15]
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).[10] 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." [7, 8, 9] Other qualified health care professionals include Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Midwives, and Certified Registered Nurse Anesthetists (CRNA).
Physician	A "physician or other qualified health care 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 his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." [7, 9] Physicians consist of Medical Doctors (MD), Doctor of Osteopathic Medicine (DO), Doctor of Chiropractic (DC), and Naturopathic Physicians (ND, NMD).

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services." Moda Health Reimbursement Policy Manual, RPM076.
C. "E0486 Oral Sleep Apnea Device/Appliance Documentation & Bundled Services." Moda Health Reimbursement Policy Manual, RPM055.
D. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.
E. "Preventive Medicine & Problem-Oriented E/M Visits, Same Day." Moda Health Reimbursement Policy Manual, RPM078.
F. "Supervised Behavioral Health Provider Program Requirements." Moda Health Reimbursement Policy Manual, RPM079.

Resources

1. AMA. "E/M Guidelines Overview." CPT book, Professional Edition, page 4 (new or revised text in 2023 edition).
2. AMA. "A Comparative Look at the Physical Medicine and Rehabilitation Codes." CPT Assistant, December 1998, page 1.
3. AMA. "Coding Tip – Evaluation and Management Codes for Preventive Services." CPT Assistant, Spring 1993, page 14.
4. AMA. "Coding Communication – Coding for Counseling." CPT Assistant, January 1998, page 5.
5. AMA. "Frequently Asked Questions - Evaluation and Management (E/M): Office or Other Outpatient Services." CPT Assistant, Volume 31 Issue 2, February 2021, page 13.
6. AMA. "Questions and Answers - Evaluation and Management E/M: Office or Other Outpatient Services." CPT Assistant, Volume 32 Issue 4, April 2022, page 12.
7. AMA. "Instructions for Use of the CPT Codebook." *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Introduction. Page xiv (new or revised text in 2023 edition).
8. AMA. "Frequently Asked Questions, Introduction." CPT Assistant, May 2015, pp. 10-11.
9. AMA. "Reporting CPT Codes for Oncology Navigation Services: The Cancer Moonshot℠." CPT Assistant, Special Edition, November Update 2023. pp. 1-11.
10. 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 .
11. CMS. "Evaluation & Management (E&M) Services." *National Correct Coding Initiative Policy Manual*. Chapter 11 Medicine, Evaluation And Management Services, CPT Codes 90000 - 99999, § U.
12. AMA. "E/M Office Visit Revisions for 2021: An Overview." *CPT Assistant,* February 2020:3-6.
13. AMA. "E/M Office or Other Outpatient Visit Revisions for 2021: Time." *CPT Assistant,* March 2020:3-5.
14. AMA. "E/M Office or Other Outpatient Visit Revisions for 2021: MDM Part 1." *CPT Assistant,* May 2020:3-8.
15. AMA. "E/M Office or Other Outpatient Visit Revisions for 2021: MDM Part 2." *CPT Assistant,* June 2020:3-9.
16. AMA. "Frequently Asked Questions – Evaluation and Management: Office or Other Outpatient Services." CPT Assistant, September 2020:14.
17. AMA. "Frequently Asked Questions – Evaluation and Management: Office or Other Outpatient Services." CPT Assistant, November 2020:12.
18. AMA. "Frequently Asked Questions – Evaluation and Management: Prolonged Services." CPT Assistant, November 2020:12.
19. AMA. "CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes." AMA. June 2020. Last accessed December 28, 2020, https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf.
20. AMA. "CPT® Evaluation and Management." AMA. Last accessed December 28, 2020 <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>.

21. NCHS. “Signs and Symptoms.” ICD-10-CM Official Guidelines For Coding and Reporting, § B.4, page 4.
22. NCHS. “Use of Sign/Symptom/Unspecified Codes.” ICD-10-CM Official Guidelines For Coding and Reporting, § B.18, page 5.
23. CMS. “Standard Anesthesia Coding.” Medicare National Correct Coding Initiative Policy Manual, Chapter 2, Anesthesia Services 00000 – 01999, § B.3.
24. OSBN. “Independent Practitioner.” Oregon State Board of Nursing, Advanced Practice Registered Nurses (APRN) Practice Guide & FAQ, page 3. Last accessed February 1, 2024. https://www.oregon.gov/osbn/Documents/FAQ_APRN.pdf .
25. Noridian, CGS. “Oral Appliances for Obstructive Sleep Apnea.” Noridian Healthcare Solutions, LLC, DME MAC J-A & J-D, & CGS Administrators, LLC, DME MAC J-B & J-C, Local Coverage Determination L33611. Last updated August 8, 2021; Last accessed February 2, 2024. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33611 .
26. Noridian. “Dentists.” Noridian Healthcare Solutions, LLC, Jurisdiction F. Last updated June 9, 2023; Last accessed February 2, 2024. https://med.noridianmedicare.com/web/jfa/topics/dental .
27. CMS. “Selection of Level of Evaluation and Management Service, General Rules.” Medicare Claims Processing Manual, Pub. 100-04, chapter 12, Physicians/Nonphysician Practitioners, § 30.6.1.A. Last updated May 9, 2023; Last accessed February 2, 2024.
28. OHA. “Fee-for-service professional billing for retail and community pharmacists.” Oregon Health Authority. Last updated October 1, 2022; Last accessed February 5, 2024. https://www.oregon.gov/oha/HSD/OHP/Tools/Pharmacist%20fee-for-service%20community%20pharmacist%20professional%20billing.pdf .
29. Moda. “Pharmacist Services Reimbursement Exploration.” Leadership from Pharmacy, Claims, Analytics, Provider Networking, Provider Configuration teams met Friday, February 2, 2024 and determined that the OHA Pharmacist Professional Billing rules will also apply to Oregon Commercial claims for pharmacist providers located in Oregon. Meeting scheduled & facilitated by Katie Scheelar, Sr Clinical Program Manager, Clinical Pharmacy, Moda Health.
30. AMA. “Coding Communication: Medication Therapy Management.” CPT Assistant, Volume 18, Issue 8, August 2008, pages 3, 15.
31. AMA. “Health Behavior Assessment and Intervention.” CPT Book, Professional Edition, Medicine Section, Health Behavior Assessment and Intervention subsection guidelines.
32. AMA. “Coding Communication - Use of the Health and Behavioral Assessment Codes.” CPT Assistant, Volume 12 Issue 3, March 2002, page 4.
33. AMA. “Health Behavior Assessment and Intervention.” CPT Assistant, Volume 30 Issue 8, August 2020, pages 3-5.
34. CMS. “Questions and Answers Regarding Payment for the Services of Therapy Students Under Part B of Medicare.” Transmittal AB-01-56. Date Published: April 11, 2001; Last accessed March 19, 2024. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/AB0156.pdf .
35. CMS. “Evaluation and Management (E/M) Services (In Teaching Settings).” *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 100.1.1.

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
3/12/2025	Clarified Behavioral Health NPs & CNSs are also eligible to report E/M codes. Formatting updates. No policy changes.

Date	Summary of Update
11/13/2024	Clarified chiropractors can report E/M codes; massage therapists cannot. Added information for dentists providing services related to oral sleep apnea devices. Updated Cross References and References & Resources. Formatting updates. No policy changes.
3/13/2024	Missing Initial Publication date added. Added Attachment of February 21, 2024 education letter to Dental for Medical providers.
2/14/2024	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
12/15/2020	Custom edit specific to provider type inappropriate for E/M codes installed into production. Based on E/M code definitions & guidelines and scope of license requirements.
7/29/2018	Original Effective Date (with or without formal documentation). Policy based on upgrade to new clinical edit system which contains edits for provider type inappropriate for procedure.

Attachment

PO Box 40384
Portland, OR 97240

February 21, 2024

Provider/Clinic
Name Street
Address
City, State ZIP code

Dear Provider,

Moda has received a significant number of inquiries and appeals on clinical edit denials of Evaluation and Management (E/M) procedure codes for *Provider Type Inconsistent with the Billed Service*. We would like to offer clarification of both the edit sourcing and recommended steps to review the denial when received.

As an insurance carrier, one of our responsibilities to our providers, our members, and our employer groups includes confirming that providers are performing services and filing claims appropriately within their scope of practice and fulfilling the requirements of the billed procedure codes.

We began work to develop and implement clinical editing in 2021 to align with this responsibility with a focus on E/M procedure codes. Various sources brought to our attention that we were allowing E/M procedure codes to providers whose Scope of License or Certification is not consistent with the E/M procedure code definitions and responsibilities of performing evaluation, diagnosis, and prescribing/treatment management functions of E/M medical decision making for medical conditions. The clinical edit utilizes the taxonomy code listed in our provider record, collected from the NPPES system, to determine denial scenarios. Note, if you have dual licensure/certifications, please ensure your primary taxonomy listed reflects your highest level of certification or scope of license.

Moda recognizes that we previously have allowed E/M procedure codes to providers who are now experiencing this denial. These changes occur as the clinical editing continues to be updated and refined periodically to consider new information brought to our attention by various sources. A significant update occurred on 10/26/22. This editing remains under active review and development to ensure we continue to be in alignment with the best information available regarding these requirements.

Although this clinical edit has affected a variety of provider types, we recognize that our Dental-for-Medical providers have been frequently affected by denials of E/M procedure codes for inconsistent provider type. Based

upon statements from LCD L33611, Article A53446, Noridian, and in CMS Pub. 100-04, ch. 12, § 30.6.1.A only dentists who are also oral surgeons may bill E/M procedure codes. Accordingly, dentists utilizing other taxonomies in the NPPES registry will receive denials of E/M procedure codes and are expected to bill dental-specific codes (Dxxxx) for any office visits for observation, evaluation, re-evaluation, etcetera.

If you are receiving denials on E/M procedure codes for *Provider Type Inconsistent with the Billed Service*, please first confirm your taxonomy code listing in NPPES reflects the correct specialty. Also, any provider who holds a dual specialty or dual licensure (e.g., dentist and oral surgeon, or Registered Nurse and Nurse Practitioner) is advised to select the taxonomy of their highest license or specialty as their primary taxonomy in NPPES, as this will be used to validate your provider record and process your Moda claims. Then contact your provider representative to request that your provider record be checked to ensure your taxonomy code matches your NPPES taxonomy listing. Should NPPES and Moda systems be consistent, please review resources included in the CPT and CMS manuals in conjunction with local state guidance for scope of license limitations.

Some of our provider contracts may still utilize older language and templates that may lead to questions on this topic. If this is the case for your provider contract and you wish to address it, please reach out to your Contract Representative to start the process of updating the provider contract to the most recent language regarding E/M codes for dentists and other providers.

Regarding E/M services provided in connection with oral sleep apnea appliances: please note that our provider contracts for this utilize a bundled case rate that includes payment for any needed visits before or after the appliance is issued. A specialty of oral surgeon does not change the bundling of E/M visits into the contracted case rate. Please reference both your provider contract for oral sleep apnea appliances and "E0486 Oral Sleep Apnea Device/Appliance Documentation & Bundled Services." Moda Health Reimbursement Policy #RPM055.

Questions?

We're here to help! Please call our Provider Relations team via email at providerrelations@modahealth.com.

Together, we can be more. We can be better.

Sincerely,

Your Moda Health Provider Relations Team