ConnectiCare

Reimbursement Policy:

Evaluation and Management Services

(Commercial and Medicare)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20220023	5/01/2020	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

This policy addresses Evaluation and Management (E/M) services, including consultations.

The E/M coding section of the CPT® book is divided into broad categories with further sub-categories which describe various E/M service classifications.

The classification of the E/M service is important because the nature of the work varies by type of service, place of service, the patient's medical status, and other code criteria, along with the amount of provider work and documentation required. The key components appear in the descriptors for most basic E/M codes and many code categories describe increasing levels of complexity.

This reimbursement policy explains when ConnectiCare may request medical records to ensure that the appropriate level of CPT E/M code is reimbursed based on the health care services provided. The code(s) reported by physicians or other health care professionals should best represent the services provided based on the American Medical Association (AMA) and CMS documentation guidelines.

Policy Statement:

While there is no prohibition on the use of proprietary templates, documentation from either an electronic health record (EHR) or hard-copy that appears to be cloned (selected information from one source and replicated in another location by copy/paste methods) from another record, including but not limited to history of present illness (HPI), exam, and MDM, would not be acceptable documentation to support the claim as billed. Templates with prepopulated responses are strongly discouraged.

REVISION HISTORY

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Office and Outpatient E/M Coding Guidelines Effective January 1, 2023

In alignment with AMA and CMS guidelines, the CPT code section for Office and Outpatient E/M Visits (99202-99205; 99211-99215) include:

- Reducing to 4 code levels for office and outpatient visits, as CMS adopted the guidelines for levels of MDM as revised by AMA, effective 1/1/2023.
    - See AMA E/M Medical Decision Making Table
- Retaining the Time element to include the total time spent providing medical care to the patient on the date of the encounter and MDM for all E/M codes
- Allowing clinicians to choose the appropriate E/M level of care based on either MDM or Time.

Time:

Time alone may be utilized to select the appropriate level of care for CPT codes: 99202-99205; 99212-99215.

E/M Documentation Requirements:

While E/M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E/M services is appropriate:

- The medical record should be complete and legible
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record.
- According to the American Medical Association (AMA), all entries to the medical record should be dated and authenticated and in a timely manner. Therefore, ConnectiCare requires medical record documentation include the signature (e.g., handwritten, electronic) of the individual who provided/ordered the services.
    - The signature for each entry must be legible and should include the practitioner's first and last names and credentials.
    - Any amendments must be signed and dated and the amended information clearly identifiable from original documentation.

The medical record must be documented by the provider/observer of services or a certified scribe only. The exceptions are the Patient Vitals, Review of Systems and/or Past, Family, Social History which may be documented by ancillary staff or via patient questionnaire. These three areas must be reviewed by the physician or non-physician practitioner (NPP) who must write a statement that it has been reviewed, corrected or additions were added. Other areas of the note documented by ancillary staff and signed by the provider are not considered acceptable documentation.

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ConnectiCare does not require medical records for all E/M services, however we may request medical records when the data indicates a physician or other health care professional has a billing pattern that deviates significantly from their peers, or claim attributes indicate possible billing errors.

Time documentation criteria for time spent face-to-face or non-face-to-face may include, but not limited to:

- Start/End Time must be documented
- Examination/Evaluation
- Counseling/Education
- Prep time for patient history/test reviews
- Documentation/Interpretation
- Care Coordination/Referring and Communication with other health care providers
- Orders for tests, procedures and medication

Time documentation criteria for time spent face-to-face or non-face-to-face may *not* include:

- Time spent by clinical staff
- Patient wait time for physician or other health care providers
- Additional distinct service procedures provided the same day as the evaluation and management service
- Travel
- Teaching that is in general and not limited to discussion that is required for management of a specific patient.

Medical Decision-Making Criteria include:

- Number and complexity of problem(s) addressed
- Amount and/or complexity of data reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Note: Per AMA guidelines: When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report (i.e. 93000, 93005, 93010), the interpretation and/or report should not be counted in the medical decision making or the reported time calculation when selecting a level of office or other outpatient E/M service.

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New vs. Established Patient:

ConnectiCare uses the CMS following definitions to determine new or established patient based:

- **New patient:** A New Patient is one who has not received any professional services from the physician, or other qualified health care professionals of the same specialty who belongs to the same group practice reporting the same Federal Tax Id (TIN) number, within the past three years.
- **Established patient:** A patient who has received professional services within the past three years by the same provider or other qualified health care professionals of the same specialty who belongs to the same group practice reporting the same Federal Tax Id number (TIN).

ConnectiCare considers other qualified health care professionals, including but not limited to, physician assistants or nurse practitioners, to be of the same specialty as the physician(s) in the same group reporting the same Federal Tax Id (TIN) number.

Medicare Reimbursement of CPT Code G2211*:

Applies to Medicare plans only. G2211 is not payable by ConnectiCare Commercial Plans.

Effective 1/1/2025, in accordance with CMS guidelines, G2211 is payable if you report the base code with modifier 25 only when the service or other procedure requiring the reporting of modifier 25 is an allowed Part B service. See Attachment 1 of CMS CR 13705 for the list of allowed preventive services. These services include:

- Part B preventive services
- Immunization administrations
- Annual Wellness Visits

Effective 1/1/2024, ConnectiCare will consider payment for add-on CPT code G2211 when reported with new and established patient E/M services.

Aligning with CMS guidelines, ConnectiCare requires G2211 to be billed **without** modifier 25 to be reimbursable. ConnectiCare will deny payment if reported on same date of service as an E/M visit (codes 99202-99205 & 99211-99215) if reported with modifier 25, for the same patient by the same provider.

Code	Description/ Type
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

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Examples: Use the following examples to assist in determining whether it is appropriate to report G2211 as an add-on to an E&M code:

***Example 1**: A patient sees you, their primary care practitioner, for sinus congestion. You may suggest conservative treatment or antibiotics for a sinus infection. You decide on the course of action and the best way to communicate the recommendations to the patient in the visit. How the recommendations are communicated is important in that it not only affects the patient's health outcomes for this visit, but it also can help build an effective and trusting longitudinal relationship between you and the patient. This is key so you can continue to help them meet their primary health care needs. The complexity that code G2211 captures isn't in the clinical condition – the sinus congestion. The complexity is in the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There's important cognitive effort of using the longitudinal doctor-patient relationship itself in the diagnosis and treatment plan. These factors make the entire interaction inherently complex. In this example, you may bill G2211.

***Example 2**: A patient with HIV has an office visit with you, their infectious disease physician. The patient tells you they've missed several doses of HIV medication in the last month because you're part of their ongoing care and have earned their trust over time. You tell them it's important not to miss doses of HIV medication, while making the patient feel safe and comfortable sharing information like this in the future. If the patient didn't share this with you, you may have decided to change their HIV medicine to another with greater side effects, even when there was no issue with the original medication. Because you're part of ongoing care for a single, serious condition such as HIV, and have to weigh these types of factors, the E/M visit is more complex. In this example, you may bill G2211.

***Examples from CMS MLN Matters MM13473*

New Patient or Established Patient Status for Emergency Department Visits:

Time is not a descriptive component for emergency department E/M levels of service. Providers must use CPT codes 99281-99285 for emergency department visits (Place of Service 23) for both established patients and new patients for the emergency department visit.

Consultations*:

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.

Consistent with CMS, ConnectiCare will not reimburse consultation codes 99242 – 99245, and codes 99252 – 99255. Non-consultative Evaluation and Management Codes may be utilized based on the code that best describes the service performed.

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Modifiers:

Modifier 25 -

Same day medical visit with procedure(s):

When performing any surgery or other medical procedure, there is a certain amount of pre and post procedural evaluation and management work that is expected to be performed as well.

Reimbursement for this E/M work is included in the payment for the primary service. When this usual pre/post procedure work is rendered without a significant, separately identifiable E/M service, it is not appropriate to report an E/M visit code, nor is it appropriate to report an E/M visit code with modifier 25.

ConnectiCare identifies when an E/M visit is reported by the same provider on the same day as a minor surgery ("0 or "10" day global period) or an endoscopic, diagnostic or therapeutic procedure (e.g., dialysis; chemotherapy; osteopathic manipulative treatment). Since the work value of an E/M service is included in the global reimbursement for a procedure, the E/M code is not eligible for separate reimbursement when identified as a "same day medical visit."

However, when "a significant, separately identifiable evaluation and management service" is performed on the same day as a minor surgery ("0 or "10" day global period) or an endoscopic, diagnostic or therapeutic procedure the evaluation and management CPT should be reported with a modifier 25.

Multiple E/M services — same day:

When multiple providers within the same billing group, of the same specialty, (using the same federal tax identification number) perform evaluation and management (E/M) services on the same patient, on the same day, ConnectiCare will reimburse only one E/M service per day. If the patient is seen elsewhere and admitted to the hospital, all services at the original visit and care at the hospital are included in the initial hospital E/M service.

Modifier 25 will be allowed when two separate visits occurred at different times of day and for unrelated problems that could not be anticipated or addressed during the same encounter*. (These claims may initially deny and may require appeal or notes to substantiate medical necessity).

**Exception: This does not apply when one of the E/M Services is a "per day" code*

This is consistent with the CMS Medicare Claims Processing Manual (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.7.B.

"For example, a scheduled office visit occurs in the morning for upper respiratory infection and 4 hours later an unscheduled visit for a fall with injured knee. Worsened existing conditions would not qualify for modifier 25. These situations will be rare and would not be expected to be seen on a routine basis."

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Initial Hospital Care/Subsequent Hospital Care – same day:

ConnectiCare will reimburse a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit code descriptors contain the phrase “per day” which means that the code and the payment established for the code represent all services provided on that date. The physician should select a single code with appropriate level of service that represents all services provided during the date of the service.

In a hospital inpatient situation involving one physician covering for another, if physician “A” sees the patient in the morning and physician” B”, who is covering for “A”, sees the same patient in the evening, physician “B” will not be reimbursed for the second visit.

If the physicians are each responsible for a different aspect of the patient’s care, ConnectiCare will reimburse both visits if the physicians are in different specialties* (excluding subspecialties under same specialty), ***or*** different group (not the same federal tax identification number) and the visits are billed with different diagnoses.

**Note: ConnectiCare recognizes physician “specialty” as defined by CMS.*

CMS Physician Specialty Codes

See “Same Day/Same Service Edits” table below for examples of edits that may be applied.

Preventive visit and problem-oriented visit — same day:

ConnectiCare will reimburse a preventive visit and a problem-oriented visit when the 25 modifier is applied to the problem-oriented visit. This should only occur when a significant abnormality or pre-existing condition is addressed, and additional work is required to perform the key components of a problem-oriented E/M service. The medical record documentation must support both services.

Components performed during the preventive service (such as ROS and Complete Standard Exam) cannot be counted towards the calculation of an additional problem visit. If a problem visit has dominated the encounter rescheduling the preventive service may be warranted to ensure complete consideration to the new issues.

Modifier 57 -

ConnectiCare’s global surgical reimbursement for major surgical procedures with a 90-day global period includes the E/M service performed one day pre-operatively or on the same day as the surgical procedure. However, when the decision for surgery occurs one day pre-operatively or on the same day as the major surgery procedure, the E/M service should be reported with the “decision for surgery” modifier 57.

Same Day/Same Service Edits:

ConnectiCare sources its Same Day/Same Service edits to methodologies used and recognized by third party authorities including, but not limited to Current Procedural Terminology book (CPT®) from the American Medical Association (AMA) and CMS National Correct Coding Initiative (CCI) edits.

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CCI:	An edit sourced to specific billing guidelines from the General Correct Coding Policies contained in the National Correct Coding Policy Manual (CCI) published by CMS. For example, the Evaluation and Management Services section (chapter xi) specifically states "A physician should not report an 'initial' per diem E&M service with the same type of 'subsequent' per diem service on the same date of service." ConnectiCare will not separately reimburse for an initial and a subsequent per diem service on the same date, such as 99222 and 99231.
CMS:	An edit sourced to specific CPT® book direction related to the reporting of exact codes or modifiers. For example, the CPT coding book states "Do not report 94002-94004 in conjunction with Evaluation and Management services 99201-99499." ConnectiCare will not separately reimburse for any service in the range 94002-94004 when reported with any service in the range of 99202-99499.

Important notice:

To ensure appropriate documentation and billing, claims may be subject to random post-payment audit and retraction. Inconsistencies found in the documentation which jeopardize the integrity of the note will be omitted during scoring and/or subject to further inquiry.

Post Audit documentation education may be assigned and required to the rendering provider.

Failure to adhere to proper coding and documentation guidelines could result in, including but not limited to, enrollment in a pre-pay review program, referral to the Special Investigations Unit or loss of in-network status.

References:

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services. CPT® is a registered trademark of the American Medical Association

AMA. “CPT® E/M Office Revisions Level of Medical Decision Making (MDM).” AMA: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

AMA. “CPT® Evaluation and Management.” AMA: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

Centers for Medicare & Medicaid Services, CMS Manual System and other CMS publications and services including but not limited to 1995/1997 guidelines.

1. 1995 Guidelines: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

2. 1997 Guidelines: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
3. Medicare Claims Processing Manual Chapter 26 Section 10.8.2 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26pdf.pdf

Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications

Novitas Solutions – Medicare Part B: "Evaluation & Management Services: Medical Decision Making: https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005056

Grider, Deborah J., Coding with Modifiers, A Guide to Correct CPT® and HCPCS Level II Modifier Usage Fourth Edition, copyright 2011 by the American Medical Association

Grider, Deborah J., Medical Record Auditor: A guide to Improving Clinical Documentation in a Changing Health Environment, Fourth Edition, copyright 2015 by the American Medical Association

Centers for Medicare & Medicaid Services. "How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211." MLN Matters MM13473: https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

Revision History

Company(ies)	DATE	REVISION
ConnectiCare	6/18/2025	• Updated policy to include Medicare coverage guidelines for G2211 **effective 1/1/2025**
ConnectiCare	6/18/2025	• Transferred policy content to individual company-branded template. No changes to policy title or policy number.
EmblemHealth ConnectiCare	2/1/2024	• Updated policy to include Medicare coverage guidelines for G2211 **effective 1/1/2024**
EmblemHealth ConnectiCare	3/2023	• Consultation section updated; removed deleted codes effective 1/01/2023: 99241 and 99251 • Updated guidelines to align with 2023 E/M Guidelines
EmblemHealth ConnectiCare	7/2022	• Updated to clarify Initial Hospital Care/Subsequent Hospital Care – same day guidelines and care provided by different specialty providers

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EmblemHealth ConnectiCare	6/2022	• Updated policy to include Initial Hospital Care/Subsequent Hospital Care – same day guidelines • Updated to include examples of Same Day/Same Service Edits
EmblemHealth ConnectiCare	3/2022	• Consultation section updated, removed coverage of codes 99241-99255 for EH CNY Plans effective **9/01/2022**. • Updated guidelines to align with 2021 E/M Guidelines • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number • Updated Time Documentation Criteria
ConnectiCare	2/2020	• Consultation section updated, removed coverage of codes 99241-99255 effective 5/01/2020.
ConnectiCare	12/2018	• Added language to clarify “Multiple E&M – Same Day” and the appropriate use of Modifier 25
ConnectiCare	6/2018	• Reformatted and reorganized policy with new Reimbursement Policy Number • Content added to outline detailed CMS and AMA Guidelines