Priority Health	BILLING POLICY No. 010
EVALUATION AND MANAGEMENT	
Date of origin: April 2024	**Review dates: 12/2024, 2/2025, 6/2025, 7/2025, 8/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

This policy addresses Evaluation and Management (E/M) services within the E/M coding section of the CPT® book.

POLICY SPECIFIC GUIDELINES

General guidelines

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 policy identifies that medical records may be requested 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 providers should accurately represent the services provided based on the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) documentation guidelines. Medical necessity of a service is the encompassing element for payment in addition to the individual requirements of an E/M visit code. Documentation should support the level of service reported.

Overcoding

Overcoding is defined as reporting procedure codes at higher level than what is warranted by the clinical documentation.

Documentation should support the medical necessity and diagnosis reported. General principles of E/M written by CMS dictate that providers report diagnosis and treatment codes on the claim form that are consistent with the documentation in the medical record. Claims billed for E/M services not supported by documentation will be denied.

Providers may choose the appropriate E/M level of care based on either Time or Medical Decision Making (MDM).

1. Selecting the level of service based on Time:

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

- 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 E/M service

2. **Selecting the level of services based on Medical Decision Making (MDM)**
   - Number and complexity of problem(s) addressed during this visit
   - Amount and complexity of data reviewed and analyzed
   - Orders for, and interpretation of data from a test or image cannot be included when determining the E/M Level of service if the test or image interpretation is billed separately
   - Risk of complications and/or morbidity or mortality of patient management

When determining the level of MDM, two of the three elements for that level must be met or exceeded. Additional information regarding the code selection based on Time or MDM and the requirements for each can be found in the Evaluation and Management (E/M) Services Guidelines of the American Medical Association CPT codebook.

Modifier 25

Modifier 25 is used to describe a "significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service."

Review our policy regarding use of modifier 25.

New vs. established patient

Review our guidelines on reporting new vs. established patient E/M codes.

Global surgical packages

Priority Health will edit claims for E/M services performed within global period for applicable services. All applicable global surgical modifiers should be utilized when supported by documentation, prior to claim submission. Review our global surgical packages information. There are also global surgery modifiers that should be considered. Review our modifier page for more information.

In addition, services that have a global surgery indicator of “XXX” have inherent pre-procedure, intra-procedure and post-procedure work. This inherent work should **not** be reported with a separate E/M code.

Review our policy regarding use of modifier 25.

Multiple visits per day

- Priority Health will reimburse one E/M visit per group and same specialty per day.

- Per our High-level E/M with preventive exam billing policy, due to the considerable similarities between the requirements for preventive exam codes and high-level E/M codes, if both are submitted together, regardless of modifier use, only the preventive exam (CPE) code will be reimbursed. Medical records can be submitted via appeal if extenuating circumstances exist for a high-level Evaluation and Management code is supported in addition to the preventive medicine services. See details in the High level E/M with preventive exam billing policy.

- If both preventive and low-level problem-oriented services are billed, documentation must support that both services were provided in their entirety as significant and separately identifiable services. Then report the problem-oriented E/M service with modifier 25. Review our modifier page for more information.

- Office, outpatient or emergency department Evaluation and Management services will be denied as unbundled when a nursing facility admission (99304-99306) has also been billed by the same physician on the same date of service for the same member.

Emergency department visits

Time is not a descriptive component for emergency department (ED) E/M levels of service. Providers must use CPT codes 99281-99285 for ED visits for new and established patients. CPT codes 99281-99285 must only be submitted for services provided in an ED as defined by AMA CPT; “as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day,” and “organized hospital-based facility” includes hospital owned free-standing EDs. Providers may experience adjustments to or denials of the office visit or other outpatient E/M code or ED E/M code reported if the documentation does not support the E/M level submitted. The provider may resubmit the claim with a revised E/M code for denied claims.

To report two separate Emergency Room visits on the same day, follow the guidance below:

Professional claims

- Indicate "second visit" in box 19, or claim will deny.

Facilities

- Enter the **27** modifier on the E&M code.

Provider is paid by APC

- Bill a **G0 condition code** and a **25 modifier**.

Psychological E/M services

Psychological E/M services are performed to address difficulties associated with an acute or chronic illness, prevent a physical illness or disability and maintain health that do not meet criteria for a psychiatric diagnosis. Find details for reporting these E/M services.

Online Digital Management Services

Online Digital Management E/M are non-face to face, time-based codes and are used when a patient initiates a portal message. These codes are billable when the provider reviews and provides a response to a new problem. These codes are not billable if there was an E/M service performed seven days prior regarding the same problem.

Related billing policies

- High level E/M with preventive exam

REFERENCES

- CPT Evaluation and Management (AMA)
- Medicare NCCI Policy Manual – Chapter 1 (CMS)
- MLN Booklet – Global Surgery (CMS)
- Medicare Claims Processing Manual - Chapter 12

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Dec. 19, 2024	Added information on global surgery indicator "XXX"
Feb. 4, 2025	Added "Disclaimer" section
June 19, 2025	Additions: • To "Global surgical packages" section: In addition, services that have a global surgery indicator of "XXX" have inherent pre-procedure, intra-procedure and post-procedure work. This inherent work should NOT be reported with a separate E&M code. • New "Online Digital Management Services" section
July 11, 2025	• Added "Emergency department visits" section with information that was already available in the Provider Manual • Added reference to the *High-level E/M with preventive exam* billing policy

Aug. 14, 2025	• Added information regarding nursing facility admission (99304-99306)