Kansas City	Evaluation and Management Guidelines	
	Policy Number: POL-PP-236	**Original Creation Date: 1/1/2023**
	Version Number: 005	**Version Effective Date: 1/1/2023**
	Policy Status: Active	**Next Review Date: 1/1/2027**

PROVIDER/ENTITY IMPACTED					
☒ PROFESSIONAL	☐ FACILITY	☐ DME	☐ AMBULATORY SURGERY	☐ LAB	☒ OTHER

LINES OF BUSINESS IMPACTED						
☒ COMMERCIAL	☒ BLUE MEDICARE ADVANTAGE	☒ ACA QHP[1]	☒ SMALL GROUP ACA	☒ JAA[2]	☒ FEP[3]	☐ DENTAL

[1] ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family [2] JAA: Joint Administrative Account [3] FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

Evaluation and Management (E/M) refers to a crucial set of medical codes (CPT 99202-99499) used by healthcare providers to bill for patient encounters like office visits, hospital care, or emergency room visits,

focusing on the complexity of the patients issues, data review, and risk level, rather than just the procedures, with recent changes emphasizing Medical Decision Making (MDM) or time as key factors for determining the billing level.

Policy

Documentation within the medical record must accurately document and support the visit level reported. Levels of E/M services are determined by complexity. Complexity of an E/M level is determined by either the level of MDM, or the total time spent on the date of the encounter.

Office visit with minor procedures (0-to-10-day global period)
All billable medical procedures include an "inherent" E/M component to gauge the patient's overall health and the medical appropriateness of the service. In general, E&M services performed on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the global surgical package for the minor surgical procedure and shall not be reported separately as an E/M service.

Modifier 25 is used to indicate that a patient's condition required a significant, separately identifiable evaluation and management (E/M) service beyond that associated with the procedure or service being reported by the same physician or other qualified health care professional (QHP) on the same date.

The E/M service must be significant and medically necessary. The problem must be distinct from the other E/M service provided (e.g., preventive medicine) or the procedure being completed. This can be defined as a problem that requires treatment with a prescription or a problem that would require the patient or family to return for another visit to address it. A minor/trivial problem or concern would not warrant the billing of an E/M 25 service.

Hospital Inpatient or Observation Care Services Same Day Admit/Discharge
For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate.

Codes 99234, 99235, 99236 require two or more encounters on the same date of which one is an initial admission encounter and another encounter being a discharge.

For a patient admitted and discharged at the same encounter (i.e., one encounter), see 99221, 99222, 99223. Do not report 99238, 99239 in conjunction with 99221, 99222, 99223 for admission and discharge services performed on the same date.

Consultation
A consultation is a type of evaluation and management service provided at the request of another physician, other qualified health care professional, or appropriate source to recommend care for a specific condition or problem.

A physician or other qualified health care professional consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. A "consultation" initiated by a patient and/or family, and not requested by a physician, other qualified health care professional, or other appropriate source (e.g., non-clinical social worker, educator, lawyer, or insurance company), is not reported using the consultation codes.

The consultant's opinion and any services that were ordered or performed must also be communicated by written report to the requesting physician, other qualified health care professional, or other appropriate source.

Request for an opinion > Render the service > Report must be written with opinion to the requesting provider

Office and Other Outpatient Services
Effective January 1, 2025, the American Medical Association implemented telehealth evaluation and management codes (98000-98015). When performing a telehealth office visit providers may use 98000-98015 or 99202-99215.

Split and Shared Visits
Modifier FS is correct for services provided as a split (shared) service between the physician and NPP in the same group.

It is to be applied to E/M services and has been expanded to include skilled nursing facilities and critical care services. The billing provider is the practitioner who provides a substantive portion of the service. When time is used the substantive portion means more than half of the total time.

Example: If the NPP first spent 10 minutes with the patient and the physician then spent another 15 minutes, their individual time spent would be summed to equal a total of 25 minutes. The physician would bill for this visit since they spent more than half of the total time (15 of 25 minutes in total).

Performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM.

Documentation in the medical record must identify the two individual practitioners who performed the split/shared visit. In addition, the individual who performed the substantive portion, and therefore bills the visit, must sign and date the medical record.

Guidelines for Selecting Level of Service Based on Medical Decision Making
Four types of MDM are recognized: straightforward, low, moderate, and high.
MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

MDM is defined by three elements. The elements are:
- The number and complexity of problem(s) that are addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed.
- The risk of complications and/or morbidity or mortality of patient management .

Blue KC uses the **2021 AMA CPT Level of MDM Table** to quantify the complexity of problems addressed, complexity of date to be reviewed and analyzed, and risk of complications and/or morbidity and mortality to determine the appropriate level of E/M service selected.

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 selected 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, exam, or diagnostic study) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

- **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).

- **Self-limited or minor problem:** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

- **Stable, chronic illness**: A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition).

'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.

For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.

- **Acute, uncomplicated illness or injury:** A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolved consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

- **Chronic illness with exacerbation, progression, or side effects of treatment**: A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.

- **Undiagnosed new problem with uncertain prognosis**: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

- **Acute illness with systemic symptoms**: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.' Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

- **Acute, complicated injury**: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

- **Chronic illness with severe exacerbation, progression, or side effects of treatment:** The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

- **Acute or chronic illness or injury that poses a threat to life or bodily function**: An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, which pose a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of service is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.

Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.

The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the nature of the condition. Multiple problems of lower severity may, taken together, create higher risk due to interaction.

Amount and/or Complexity of Data to Be Reviewed and Analyzed

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter.

Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed.

Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

- **Test:** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purpose of data being reviewed and analyzed, pulse oximetry is not a test.

- **Unique:** A unique test is defined by the CPT code set. When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements

are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

- **Combination of Data Elements**: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

- **External:** External records, communications, and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

- **External physician or other qualified health care professional:** An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

- **Discussion:** Discussion requires interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (i.e., does not need to be in person), but it must be initiated and completed within a short time period (e.g., within a day or two).

- **Independent historian(s):** An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a 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. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

- **Independent interpretation:** The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Risk of Complications and/or Morbidity or Mortality of Patient Management

The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty.

Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities).

For MDM, the level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

- **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.

- **Social determinants of health:** Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

- **Surgery** (minor or major, elective, emergency, procedure, or patient risk):
    - Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk." These terms are not defined by a surgical package classification.

    - Surgery—Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

    - Surgery—Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

- **Drug therapy requiring intensive monitoring for toxicity:** A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify.

Monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (e.g., Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face time with the patient and/or family/caregiver, and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It includes time regardless of the location of the physician or other qualified health care professional (e.g., whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent on the performance of other separately reported service(s). Providers must carve out time spent performing billable services from E/M time

Physician or other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history.
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring to and communicating with other health care professionals (when not separately reported)
- documenting clinical information in electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.
- care coordination (not separately reported)

Do not count time spent on the following:

- the performance of other services that are reported separately (e.g., procedures that are separately billable).
- travel
- teaching that is general and not limited to discussion that is required for the management of a specific patient

Coding

Codes	Description	E/M Level Selection
99202-99215	Office or other Outpatient Service (office and telehealth)	Medical Decision Making or total time spent
99221 - 99223	Initial Hospital inpatient or Observation Care	Medical Decision Making or total time spent

99231-99233	Subsequent Hospital inpatient or Observation Care	Medical Decision Making or total time spent
99234 -99236	Hospital Inpatient or Observation same day admit/discharge	Medical Decision Making or total time spent
99242-99245 99252-99255	Consultation – Inpatient/Observation/office	Medical Decision Making or total time spent
99281-99285	Emergency Department Services	Medical Decision Making
99304 -99310	Nursing Facility Care (Initial and Subsequent)	Medical Decision Making or total time spent
99341-99350	Home or Residence Services (new or established)	Medical Decision Making or total time spent
99468 -99476	Neonatal and Pediatric Critical/Intensive Care	Total time
99291-99292	Critical Care	Total Time

References and Resources

Blue KC Provide Reference Guide
Centers for Medicare and Medicaid Services
American Medical Association CPT Manual

Related Documents

POL-PP-192 Critical Care Services
POL-PP-200 Newborn and Neonatal Intensive Care (NICU) Services
POL-PP-197 Emergency Care
POL-PP-258 Facility Observation G0378, G0379

Revision History

Version	Date	Summary of Revisions
001	1/1/2023	Initial Version
002	1/30/2023	Update, Information on 48-hour Facility Observation added
003	3/8/2023	Update, Information on modifier FS added
004	1/1/2024	Annual review, time range for new and established patient removed, added definition to substantive portion of shared visit in line with 2024 updates
005	1/1/2025	Annual review, removed detailed information on 2021 and 2023 E/M updates
006	1/1/2026	Annual review, table added for code selection based on MDM and/or time, removed information for hospital facility observation, and added Facility Observation Policy to related documents. Added link to AMA Medical Decision making table