JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.025
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	Subject **Evaluation and Management (E/M) Services**	*Supersedes Date*	09/15/2023
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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and may follow CMS guidelines and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

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

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

This policy provides basic reimbursement guidance on the appropriate reporting of Evaluation and Management (E/M) services, when rendered within the provider's scope of practice, under state and federal law. JHHP will process claims for E/M services reported on a CMS-1500 or CMS-1450 (UB-04) or their electronic equivalents, when billed in accordance with regulatory, state and federal guidance. This policy is applicable for both participating and nonparticipating providers, who submit claims to JHHP for payment.

III. POLICY STATEMENT

JHHP will reimburse covered E/M services rendered by network and non-network providers, in accordance with CMS and CPT guidelines, when all technical requirements and billing guidelines are met, and in accordance with member plan benefits. JHHP has identified CPT codes and HCPCS code that are not payable, not covered, or bundled (not separately reimbursed) which are applicable to this policy. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, member's benefit coverage, prior authorization requirements, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. GENERAL BILLING GUIDELINES FOR E/M SERVICES

A. JHHP adopts the most current CPT E/M guidelines for determining visit levels. For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the AMA's CPT book and any applicable documentation guidelines.
   - Refer to the AMA CPT E/M descriptors and guidelines for additional information.

B. In alignment with CMS and CPT guidance, the E/M service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which they practice, and to bill the appropriate level of visit code for the services furnished.

C. It would not be medically necessary or appropriate to bill a higher level of an E/M service when a lower level of service is warranted.

D. JHHP will evaluate the appropriateness of levels of E/M codes to determine whether the level of service billed matches the intensity of the service and the severity of the illness. These are considered administrative, not clinical, reviews based on correct coding guidelines. As such, JHHP reserves the right to either:
   1. Deny the claim
   2. Request resubmission of the claim with the appropriate E/M level
   3. Pend the claim and request documentation supporting the E/M level billed; and/or
   4. Adjust reimbursement to reflect the lower E/M level supported by the claim.

E. Consistent with CPT coding guidance, providers may choose the appropriate E/M level of care based on either Time or Medical Decision Making (MDM). Under certain circumstances, an exception may apply.

F. JHHP will align with NCCI and MUE guidance to process E/M claims, when applicable.

G. When billing for psychotherapy services (CPT codes 90832 – 90838) with an E/M visit, individuals who bill for psychotherapy services must meet the training requirements and state licensure or authorization, as these services require an adequate level of expertise in the cognitive skills required for the performance of diagnostic and therapeutic psychological services.

V. APPROPRIATE USE of MODIFIERS

A. Consistent with CMS and CPT guidance, modifier 25 can only be appended to an E/M service. When modifier 25 is incorrectly reported with a non-E/M service or procedure code, the service/procedure will be denied.

B. Modifier 25 may be appended to an E/M code only when a significant, separately identifiable service or procedure is rendered by the same provider, on the same date of service (DOS) and the separately identifiable service or procedure is also reported on the claim.
   - Do not append modifier 25 to the E/M code when only an E/M service is performed and there is not a significant, separately identifiable service or procedure reported on the claim form.
     - *Example: It is not appropriate for a provider to only report CPT 99213 -25, and no other CPT code is reported on the claim, for the same encounter.*

C. Modifier 25 should not be reported on procedure code 99211.

D. Inappropriate modifiers (i.e., 59, 53, 76, etc.) should not be appended to an E/M code or the service will be denied.

E. In alignment with CMS guidance, when modifier FS is reported, the amount of time spent must be clearly documented and must be the primary consideration as the key or controlling factor in selecting the level of service.

F. When billing for split/shared critical care visits, only the provider who performed the substantive portion may bill for services. Modifier FS must be appended to the critical care CPT code(s) on the claim.
   - JHHP does not consider counseling by other clinical staff members to be a part of the face-to-face physician/patient encounter time.

VI. NEW PATIENT VS. ESTABLISHED PATIENT

A. When a professional component of a previous procedure is billed in a 3-year time period, (e.g., lab interpretation) and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit.

B. If a patient was seen by a physician in a clinic and sometime during the 3-year period was seen again by that same physician at the same clinic, at another clinic, or in the physician's private practice, this is still an established patient situation.
   - When a patient sees another physician of the same specialty and subspecialty at a location where the first physician also practices, this is also an established patient situation.

C. No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

VII. OFFICE/OUTPATIENT E/M VISITS PROVIDED ON SAME DAY

A. Consistent with CMS, JHHP will not reimburse for two E/M office visits, billed by a physician (or physician of the same specialty or subspecialty, from the same group practice) for the same member, on the same day, unless the physician accurately documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter, and the appropriate modifier is appended.

B. JHHP will not separately reimburse a physician when they report an "initial" per diem E/M service with the same type of "subsequent" per diem service on the same date of service (e.g., CPT 99223 and CPT 99232 billed on the same date of service.)

C. If multiple E/M visits occur on the same day, the provider must select a level of service representative of the combined visits and submit the appropriate code for that level, as service should be reported with the most single, comprehensive CPT code.

VIII. E/M SERVICES FURNISHED INCIDENT TO PHYSICIAN'S SERVICE BY NONPHYSICIAN PRACTITIONERS

A. When E/M services are furnished incident to a physician’s service by a non-physician practitioner, the physician may bill the CPT code that describes the E/M service furnished.

B. A physician is not precluded from billing under the “incident to” provision for services provided by employees whose services cannot be paid for directly. Employees of the billing physician may provide services incident to the physician’s service, but only the physician alone is permitted to bill JHHP for services.

IX. E/M SERVICES PROVIDED DURING GLOBAL PERIOD OF SURGERY

A. JHHP aligns with CMS guidance for E/M services provided during a global surgical period. Please refer to the appropriate CMS website for more information on this topic.

B. An E/M service provided on the same day of a procedure, with a global fee period, will be eligible for reimbursement only when documentation supports that the service is for a significant, separately identifiable service that is above and beyond the usual pre and post-operative work of the procedure and the appropriate modifier is used.

C. Refer to CMS guidance for E/M services performed the day before major surgery, on the day of major surgery, and/or an E/M service that results in the initial decision to perform the surgery, as payment methodologies can vary.

D. For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the AMA’s CPT book and any applicable documentation guidelines.

X. USE OF EMERGENCY DEPARTMENT (ED) CODES IN AN OFFICE SETTING

A. Physicians must utilize the appropriate E/M code for an office/outpatient visit. Emergency department (ED) coding is not appropriate if the site of service is an office or outpatient setting or any site of service other than an ED.

B. If the physician asks the patient to meet them in the ED as an alternative to the physician’s office and the patient is not registered as a patient in the emergency department, the physician should bill the appropriate office/outpatient visit codes.

XI. EXCEPTIONS and EXCLUSIONS

A. **AMD:** JHHP will process and reimburse E/M claims in accordance with Medicare guidance. Please consult the authoritative guidance found on the CMS website and Medicare manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

B. **PPMCO**: JHHP will process and reimburse E/M claims in accordance with the Maryland Department of Health (MDH) and the Code of Maryland Regulations (COMAR) guidance. Please consult the authoritative guidance found on the MDH website to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

C. **USFHP:** JHHP will process and reimburse E/M claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

XII. CODES, TERMS & DEFINITIONS

Definition of Terms

TERM	DEFINITION
Clinical Staff Member	A person (e.g., nurse, phlebotomist, or other health professional) 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 specific professional service, but does not individually report that professional service.
Emergency Department (ED)	A hospital facility that is staffed 24 hours a day, 7 days a week, and provides unscheduled outpatient services to patients whose condition requires immediate care.
Established Patient	An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

Evaluation and Management (E/M) Services	Per the CPT manual, E/M services (CPT 99202-99499) guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare professional to select the appropriate level of service. The E/M section of the CPT® manual is divided into broad categories and further divided into sub-categories of E/M services.
Office Visit	A physician's ambulatory practice (office) may be in a location other than in a hospital, nursing home, other extended care facility, patient's home, industrial clinic, college clinic, or family planning clinic. An office visit is any direct personal exchange between an ambulatory patient and a physician or members of their staff for the purpose of seeking care and rendering health services.
Global Period	The period of time during which claims for related services will be considered directly related to pre-procedure, intra-procedure, and post-procedure work are included in the global reimbursement and will not be paid separately.
Outpatient	An outpatient is a person who has not been admitted by the provider as an inpatient and is not lodged in the provider facility while receiving its services. Where a provider uses the category "day patient;" i.e., an individual who receives the facility's services during the day and is not expected to be lodged in the facility at midnight, the individual is classified as an outpatient.
Outpatient Services	Outpatient services include services that are diagnostic in nature as well as those services and supplies which are incident to the services of physicians in the treatment of patients.
Physician or Other Qualified Health Care Professional (OQHCP)	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privilege (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

New Patient	A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN). Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.
Split/Shared Services	A split/shared evaluation and management visit, as defined by CMS, is one that is performed by both a physician and a non-physician practitioner (NPP) who bill under the same tax identification number (TIN) and are in the same specialty group.

Modifiers

MODIFIER	DEFINITION
24	Unrelated evaluation and management (E/M) service by the same physician during a postoperative period.
25	A significant, separately identifiable evaluation and management (E/M) by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.
57	Decision for surgery; An evaluation and management (E/M) service that resulted in the initial decision to perform the surgery may be identified by adding this modifier to the appropriate level of E/M service.
59	Distinct procedural service.
FS	Split (or shared) evaluation and management (E/M) visit.

Procedure codes (CPT® & HCPCS)

CODE	CODE DESCRITPTION

99202-99499	Please refer to the AMA CPT book for all Evaluation and Management (E/M) CPT descriptors located in the E/M section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details.

XIII. REFERENCES

This policy has been developed through consideration of the following:

- CMS Regulations & Guidance
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT® Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- JHHP E&M Resources
- JHHP Reimbursement Policies
- Maryland Medicaid Professional Services Provider Manual
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Benefit Policy Manual- Chapter 15
- Medicare Claims Processing Manual- Chapter 12
- NCCI for Medicaid | CMS
- NCCI for Medicare | CMS
- TRICARE Reimbursement Manual

XIV. APPROVALS

DATE	REVIEW or REVISION	REASON FOR MODIFICATION	APPROVED BY
10/17/2024	Revision	Updated: policy formatting, policy language, references, tables	Reimbursement Policy Committee (RPC)
7/08/2023	New Policy	Initial Release	Reimbursement Authorizations and Coding Committee (RAC)