CLINICAL PAYMENT AND CODING POLICY

If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Evaluation and Management (E/M) Coding – Professional Provider Services

Policy Number: CPCP024

Version 3.0

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Plan Effective Date: May 1, 2022 (Blue Cross and Blue Shield of Texas Only)

Description

This policy applies to professional providers (physicians or other qualified health care professionals) who bill for Evaluation and Management (E/M) services on CMS 1500 and/or UB04 forms. The code(s) reported by providers should best represent the services provided based on the AMA and CMS documentation guidelines. The information in this policy serves as a reference resource for the E/M Services described and is not intended to be all inclusive. This policy applies to In-network and out of network professional providers.

Claim submissions coded with the correct combination of procedure code(s) is critical to minimizing delays in claim(s) processing. Professional claims submissions should contain the appropriate CPT, HCPCS, NDC codes and ICD diagnosis codes.

The Plan reserves the right to request supporting documentation. Claims that do not adhere to coding and billing guidelines may result in a denial or reassigned payment rate. Claims are reviewed on a case-by-case basis.

Reimbursement Information:

The member's medical record documentation of services rendered by the provider must indicate the presenting symptoms, diagnoses and treatment plan, and a written order by the provider. All contents of medical records should be clearly documented, including clinical notes, consultation notes, lab reports, pathology reports and radiology reports.

Medical records and itemized bills may be requested from the provider for review to validate the site of service, level of care rendered, and services billed were accurately reported. Medical records may be reviewed to determine the extent of history, extent of examination performed, complexity of medical decision making (number of diagnoses or management options, amount and/or complexity of data to be reviewed and risk of complications and/or morbidity or mortality) and services rendered. This information, in conjunction with the level of services billed for the level of care rendered, may be reviewed and evaluated to determine if the level of service was appropriately billed.

Professional Level of Service Guideline

E/M services are broken down into three (3) key components to determine the most appropriate E/M level of care code for services rendered: (i) Extent of History, (ii) Extent of Examination Performed and (iii) Medical Decision-Making Complexity. The three components have different levels outlined within this policy. For additional information that is not captured below, refer to CMS published documentation guidelines for evaluation and management services.

History is documented with four types: (i) Problem focused, (ii) Expanded Problem Focused, (iii) Detailed and (iv) Comprehensive. There are four elements required for each type of history: Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS), and Past, Family, and/or Social History (PFSH). The plan follows the CMS Documentation Guidelines for E/M services. The table below depicts the elements required for each type of history; to qualify for a given type of history, all four elements indicated in the row must be met. Note, CC is indicated at all levels.

- CC, ROS, and PFSH may be listed as separate elements, or they may be included in the description of the HPI.

Type of History	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused		Brief Problem	Problem Pertinent	N/A
Detailed		Extended	Extended	Pertinent
Comprehensive		Extended	Complete	Complete

Exam is documented with four types of examinations: (i) Problem Focused, (ii) Expanded Problem Focused, (iii) Detailed, and (iv) Comprehensive. As outlined below, the type and extent of the examination performed is based on clinical judgement, member's history and nature of the presenting problem(s).

Exam	Problem Focused: Limited exam of the affected body area or organ system.	Expanded Problem Focused: Limited exam of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).	Detailed: Extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).	Comprehensive: General multi-system exam, or complete exam of a single organ system and other symptomatic or related body area(s) or organ system(s).

Medical Decision Making is documented by the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering these factors:

- The number of possible diagnosis and/or number of management options to be considered.
- The amount and/or complexity of medical records, diagnostic tests, notes, reports or other information that must be obtained and reviewed and analyzed.
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities that are associated with the member's presenting problems, diagnostic procedures and/or possible management options.

The table below shows the types of medical decision making, number of diagnosis or management options, amount and/or complexity of data to be reviewed and the risk of significant complications, morbidity or mortality. To qualify for a specific type of medical decision-making, two of the three elements must either be met or exceeded.

Type of Medical Decision-Making:	Straight Forward	Low Complexity	Moderate Complexity	High Complexity
Presenting Problems	1 self-limited or minor problem.	2 or more self-limited or minor problems.	1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment.	1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment.
1. Number of Diagnosis or Management Options:	Minimal	Low	Moderate	High
2. Amount and/or Complexity of Data to be Reviewed	Minimal or None	Limited	Moderate	Extensive
3. Risk of Significant Complications, Morbidity, and/or Mortality	Minimal	Low	Moderate	High

E/M CPT Codes -The inclusion of a code below does not guarantee reimbursement.

For a current list of E/M codes with details including time parameters, refer to the most current version of the American Medical Association (AMA) CPT or HCPCS codebook. This policy does not apply to all E/M codes listed in the E/M section of the CPT Codebook. CPT codes listed below may be subject for review before payment can be made:

99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99356, 99357, 99358, 99359, 99281, 99282, 99283, 99284, 99285, 99415, 99416, 99417

Split or Shared Visits

Split or shared visits is an E/M visit in the facility setting where services are performed in part by both a physician and a NPP who are in the same group, per applicable law and state/federal regulations, when the service could be billed by either the physician or NPP independently. Eligible reimbursement will be made to the practitioner who performs the substantive portion of the visit. The substantive portion is one of the key components, e.g., history, physical exam or medical decision making, or it can be more than half of the total time (not including critical care).

Providers should include modifier **-FS** on claims to identify a split or shared visit. Additionally, documentation must identify the two providers who performed the visit and include a date and signature by the provider who provided the substantive portion.

Critical Care codes **99291** and **99292** are reviewed using the criteria listed in the American Medical Association, CPT Codebook:

- **99291** Critical Care First Hour: First 30-74 minutes of critical care. There is a 30-minute time requirement for billing of critical care. The administration and monitoring of IV vasoactive medications (such as adenosine, dopamine, labetalol, metoprolol, nitroglycerin, norepinephrine, sodium nitroprusside, continuous infusion (drips), etc. is indicative of critical care.
- **99292** Additional 30 minutes: CPT 99291 plus additional 30-minute increments (beyond the first 74 minutes). Medical records must document the total critical care time.

Office or Other Outpatient CPT Codes 99202-99205 (New Patient) and 99212-99215 (Established Patient) [1]

The E/M office or other outpatient services CPT codes, (99202-99205, 99212-99215) do **not** require documentation of the extent of history or the extent of examination performed components for eligible reimbursement. As of January 1, 2021, the Plan will accept the following:

1. The level of the medical decision making for each service;
    a. **Medical decision making** is documented by the complexity of establishing the diagnosis and/or management options that are measured by:
        i. The number of possible diagnosis and/or number of management options to be considered;
        ii. The amount and/or complexity of medical records, diagnostic tests, notes, reports or other information that must be obtained and reviewed and analyzed;
        iii. The risk of significant complications, morbidity and/or mortality, as well as comorbidities that are associated with the member's presenting problems, diagnostic procedures and/or possible management options.

OR

2. The total time for E/M services performed on the date of the encounter. (See time chart below)

Level of Medical Decision Making (1)

Type of Medical Decision-Making:	**Straight Forward**
CPT Code(s)	**99202**- Office O/P NEW SF 15-29 MIN **99212**- Office O/P EST SF 10-19 MIN
Presenting Problems	1 self-limited or minor problem.
Number of Diagnosis or Management Options	Minimal
Amount and/or Complexity of Data to be Reviewed	Minimal or None
Risk of Significant Complications, Morbidity, and/or Mortality	Minimal risk of morbidity from additional diagnostic testing or treatment

Type of Medical Decision-Making:	**Low Complexity**
CPT Code(s)	**99203**- Office O/P NEW LOW 30-44 MIN **99213**- Office O/P EST LOW 20-29 MIN
Presenting Problems	• 2 or more self-limited or minor problems; **or** • 1 stable chronic illness; **or** • 1 acute, uncomplicated illness or injury
Number of Diagnosis or Management Options	Low
Amount and/or Complexity of Data to be Reviewed	Limited Must meet criteria[1]
Risk of Significant Complications, Morbidity, and/or Mortality	Low risk of morbidity from additional diagnostic testing or treatment

Type of Medical Decision-Making:	Moderate Complexity
CPT Code(s)	**99204**- Office O/P NEW MOD 45-59 MIN **99214**- Office O/P EST MOD 30-39 MIN
Presenting Problems	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • 2 or more stable chronic illnesses; **or** • 1 undiagnosed new problem with uncertain prognosis; **or** • 1 acute illness with systemic symptoms; **or** • 1 acute complicated injury
Number of Diagnosis or Management Options	Moderate
Amount and/or Complexity of Data to be Reviewed	Moderate Must meet criteria[1]
Risk of Significant Complications, Morbidity, and/or Mortality	Moderate risk of morbidity from additional diagnostic testing or treatment

Type of Medical Decision-Making:	High Complexity
CPT Code(s)	**99205**- Office O/P NEW HI 60-74 MIN **99215**- Office O/P EST HI 40-54 MIN
Presenting Problems	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • 1 acute or chronic illness or injury that poses a threat to life or bodily function
Number of Diagnosis or Management Options	High
Amount and/or Complexity of Data to be Reviewed	Extensive Must meet criteria[1]
Risk of Significant Complications, Morbidity, and/or Mortality	High risk of morbidity from additional diagnostic testing or treatment

Total time spent on the date of the encounter (2)-Time is calculated by the total time on the date of the encounter including both face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional. Documentation should support the time for each code billed.

CPT Code (New)	Time	CPT Code (Established)	Time
99202	15-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99213	20-29 minutes
99204	45-59 minutes	99214	30-39 minutes
99205	60-74 minutes	99215	40-54 minutes

CPT Code 99211

99211- Office O/P EST MINIMAL PROB

CPT code **99211** is eligible for reimbursement if the physician or other qualified health care professional's time is spent in the supervision of clinical staff who perform face-to-face services in the office or other outpatient office setting.

Prolonged Service(s) CPT Codes 99354-99359 and 99415-99417

Prolonged service CPT Codes **99354-99357** are considered add-on codes and should not be billed without the appropriate primary code. Codes **99354-99357** are billed when a physician or other qualified health care professional rendered a prolonged service(s) that involved direct patient contact that was provided beyond the usual service in an inpatient, outpatient or observation setting except with office or other outpatient services.

Physicians and other qualified health care professionals may bill CPT codes **99354** and **99355** when billing the total duration of face-to-face time spent on a given date when they provided services in the outpatient setting even if the time spent on that date was not continuous. Physicians and other qualified health care professionals may bill CPT codes **99356** and **99357** when billing the total duration of time that was spent at the bedside and on the patient's floor or unit in the hospital or nursing facility on a given date that involved prolonged service to a member even if the time spent was not continuous. Prolonged service (**99354** and **99356**) of **less than 30-minutes** total duration on a given date should not be billed separately. Prolonged service (**99355** and **99357**) of **less than 15-minutes** beyond the first hour or less than 15 minutes beyond the final 30-minutes should not be billed separately.

Physicians and other qualified health care professionals may bill CPT codes **99358** and the add-on code **99359** when billing for prolonged services rendered that is neither face-to-face time in the outpatient, inpatient, or observation setting, nor additional unit/floor time in the hospital or nursing facility setting. These codes may be billed for the total duration of time of the non-face-to-face time by the physician or other qualified health care professional even if the time spent

by the physician or other qualified health care professional is not continuous. These codes are not eligible for reimbursement when billed with CPT codes **99202-99215** but may be eligible when billed during the same session of other E/M services.

CPT codes 99415 and 99416 are add-on codes that may be billed to report a prolonged E/M service provided in the office or outpatient setting for prolonged clinical staff face-to-face time beyond the typical face-to-face time as long as a physician or other qualified health care professional is present to provide direct supervision. These codes are utilized to report the total duration of face-to-face time spent by the clinical staff on a given date, even if the time is not continuous. Note, time spent on separately reported services other than the E/M service should not be counted toward the prolonged service times.

As of January 1, 2021, the Plan will reimburse for add-on CPT code **99417** when billed separately in addition to the primary procedure codes **99205** and **99215** for office or other outpatient E/M service(s) that is beyond the usual service of the total time on the date of the primary service with **or** without direct member contact for each 15 minutes. In addition, **99417** should only be utilized for the time alone and not on the medical decision making. Documentation should support the time for each code billed. Services rendered less than 15 minutes should **not** be billed using **99417**. Note, CPT code 99417 and HCPCS code G2212 cannot be submitted at the same time. Additionally, Industry guidelines state when billing Medicare for services described in **G2212/99417**, providers should use **G2212** instead of **99417**. For non-Medicare billing, the plan will accept either code G2212 or 99417 when billed appropriately.

Note, time spent rendering separately billed service(s) other than the E/M or psychotherapy service(s) is not counted toward the prolonged service time.

+99354- PROLNG SVC O/P 1ST HOUR (Allowed only once per date, to bill the first hour of prolonged service on a given date, dependent upon the place of service. Cannot be billed with CPT codes 99202-99215)
+99355- PROLNG SVC O/P EA ADDL 30 (Used to bill each additional 30-minutes beyond the first hour, dependent upon the place of service)
+99356- PROLNG SVC I/P/OBS 1ST HOUR (Allowed only once per date, to bill the first hour of prolonged service on a given date, dependent upon the place of service)
+99357- PROLNG SVC I/P/OBS EA ADDL (Used to bill each additional 30-minutes beyond the first hour, dependent upon the place of service)
99358-PROLONG SERVICE W/O CONTACT (Allowed only once per date, to bill the first hour of prolonged service on a given date regardless of the place of service. Cannot be billed with CPT codes 99202-99215)
+99359-PROLONG SERV W/O CONTACT ADD (Used to report each additional 30-mintues beyond the first hour or to report the final 15-30 minutes of prolonged service on a given date)

+99415-PROLNG CLIN STAFF SVC 1ST HR (Used to report prolonged clinical staff time beyond the typical service time during the E/M service in the office or outpatient setting. This code should not be billed in conjunction with CPT code 99417)
+99416-PROLNG CLIN STAFF SVC EA ADD (Used to report each additional 30 minutes for prolonged clinical staff time beyond the typical service time during the E/M service in the office or outpatient setting. This code should be billed in conjunction with CPT code 99415 and should not be billed in conjunction with CPT code 99417)
+99417- PROLNG OFF/OP E/M EA 15 MIN (Used to bill each additional 15 minutes beyond the total time on the date of the primary E/M service, either with **OR** without direct member contact. Can only be billed with 99205 or 99215 if the codes were selected based on the time alone and not medical decision making)
G2212- Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact. This code is not reported for any time unit less than 15 minutes. This code is listed separately in addition to CPT codes 99205, 99215 for office or other outpatient E/M services.

References:

[1]AMA CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes.

Department of Health and Human Services Centers for Medicare & Medicaid Services, Evaluation and Management Services Guide: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Center for Medicare and Medicaid Services: 1997 Documentation Guidelines for Evaluation and Management Services: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf

Policy Update History:

Approval Date	Description
10/04/2019	New Policy
09/25/2020	Annual Review, Disclaimer update; Verbiage update
12/07/2020	Added new code number
12/23/2021	Annual Review