Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-057		
Subject:	Evaluation & Management Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	August 30, 2024	**Revised Date:**	August 2024
Date Reviewed:	July 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy addresses the Plan's requirements (which may differ from Center's for Medicaid and Medicare Services (CMS) requirements) for selecting the level of a reported Evaluation and Management (E/M) service and the eligibility for E/M reimbursement based on the fulfillment of the required criteria.

REIMBURSEMENT GUIDELINES:

As of January 1, 2023, all Evaluation and Management services are now selected and scored based on medical decision-making (MDM) or time. Since January of 2021, this change has been in effect for New Patient or Other Outpatient Services, and Established Patient or Other Outpatient Services. Therefore, the following code sets will follow selecting the level of service based on Time or MDM:

- New Patient or Other Outpatient Services (99202 - 99205)
- Established Patient or Other Outpatient Services (99211 - 99215)
- Non-Office E/M codes (99221 - 99223, 99231 - 99239)
- Emergency Department codes (99281 - 99285)
- Nursing Facility service codes (99304 - 99310, 99315, 99316)
- Home or Residence Service codes (99341, 99342, 99344, 99345, 99347 - 99350)

Note: Emergency Department codes (99281 - 99285) use only MDM to determine level of care.

Level based on Time

Time documentation criteria for time spent face-to-face or non-face-to-face may include, but 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

Note: Time spent by clinical staff, Patient wait time for physician or other health care providers, and additional distinct service procedures provided the same day as the evaluation and management service cannot be counted towards the selection of level of service based on time.

Level based on Medical Decision Making (MDM)

- 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: The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation but may be counted as ordered or reviewed for selecting an MDM level.

For purposes of the medical record audits of E/M coding levels, the Plan's position is that the complexity of the presenting complaint and medical decision making (MDM) should align with the complexity of the patient history and physical examination. Also, when determining the level of MDM, two of the three elements for that level must be met or exceeded.

New Patient Services

The Plan will no longer require the 3 components or reference face to face time when reporting New Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL TIME
99202	Medically appropriate History and exam	Straightforward	15 minutes must be met or exceeded
99203	Medically appropriate History and exam	Low	30 minutes must be met or exceeded
99204	Medically appropriate History and exam	Moderate	45 minutes must be met or exceeded
99205	Medically appropriate History and exam	High	60 minutes must be met or exceeded

Established Patient Services

The Plan will no longer require 2 of 3 components or reference face to face time when reporting Established Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99211	Minimal problem that may not require the presence of a physician or other qualified health care professional	N/A	N/A
99212	Medically appropriate History and exam	Straightforward	10 minutes must be met or exceeded
99213	Medically appropriate History and exam	Low	20 minutes must be met or exceeded
99214	Medically appropriate History and exam	Moderate	30 minutes must be met or exceeded
99215	Medically appropriate History and exam	High	40 minutes must be met or exceeded

Non-Office E/M Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99221	Medically appropriate History and/or exam	Straightforward or Low	40 minutes must be met or exceeded
99222	Medically appropriate History and/or exam	Moderate	55 minutes must be met or exceeded
99223	Medically appropriate History and/or exam	High	75 minutes must be met or exceeded
99231	Medically appropriate History and/or exam	Straightforward or Low	25 minutes must be met or exceeded
99232	Medically appropriate History and/or exam	Moderate	35 minutes must be met or exceeded
99233	Medically appropriate History and/or exam	High	50 minutes must be met or exceeded
99234	Medically appropriate History and/or exam	Straightforward or Low	45 minutes must be met or exceeded
99235	Medically appropriate History and/or exam	Moderate	70 minutes must be met or exceeded
99236	Medically appropriate History and/or exam	High	85 minutes must be met or exceeded
99238	N/A	N/A	30 minutes or less
99239	N/A	N/A	More than 30 minutes

Nursing Facility Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99304	Medically appropriate History and/or exam	Straightforward or Low	25 minutes must be met or exceeded
99305	Medically appropriate History and/or exam	Moderate	35 minutes must be met or exceeded

99306	Medically appropriate History and/or exam	High	50 minutes must be met or exceeded
99307	Medically appropriate History and/or exam	Straightforward	10 minutes must be met or exceeded
99308	Medically appropriate History and/or exam	Low	20 minutes must be met or exceeded
99309	Medically appropriate History and/or exam	Moderate	30 minutes must be met or exceeded
99310	Medically appropriate History and/or exam	High	45 minutes must be met or exceeded
99315	N/A	N/A	30 minutes or less
99316	N/A	N/A	More than 30 minutes

Home or Residence Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99341	Medically appropriate History and/or exam	Straightforward	15 minutes must be met or exceeded
99342	Medically appropriate History and/or exam	Low	30 minutes must be met or exceeded
99344	Medically appropriate History and/or exam	Moderate	60 minutes must be met or exceeded
99345	Medically appropriate History and/or exam	High	75 minutes must be met or exceeded
99347	Medically appropriate History and/or exam	Straightforward	20 minutes must be met or exceeded
99348	Medically appropriate History and/or exam	Low	30 minutes must be met or exceeded
99349	Medically appropriate History and/or exam	Moderate	40 minutes must be met or exceeded
99350	Medically appropriate History and/or exam	High	60 minutes must be met or exceeded

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows Centers for Medicare and Medicaid Services (CMS) guidelines for Evaluation and Management services.

DEFINITIONS:

Term	Definition
New Patient	Individual who has not received any professional services, Evaluation and Management (E/M) service or other face-to-face service (e.g., surgical procedure) from the same physician and/or other qualified health care professional or physician group practice (same physician specialty/sub-specialty) within the previous three years.

Established Patient	An established patient is one who has received professional services, E/M service or other face-to-face service (e.g., surgical procedure) from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

REFERENCES:

- *Medicare Claims Processing Manual*, Chapter 12; section 30.6.1: Selection of Level of Evaluation and Management Service Based on Duration of Coordination or Care and/or Counseling.
- American Medical Association; CPT® Evaluation and Management (E/M) Code and Guideline Changes
- Centers For Medicare and Medicaid Services; MLN Network: MLN 006764 January 2022

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- *Highmark Provider Manual*, Chapter 6; Unit 4: Selecting a Level of Medical Decision Making for Coding and Evaluation and Management Service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-020: Preventive Medicine and Office/Outpatient Evaluation and Management Services
- RP-035: Correct Coding Guidelines
- RP-037: Emergency Evaluation and Management Coding Guidelines

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Implementation
4 / 2021	Added note for G2211
11 / 2021	Added NY region applicable to the policy
5 / 2023	Updated with CMS 2023 changes to Evaluation and Management direction
1 / 2024	Updated note on Level Based on MDM and removed note for G2211
4 / 2024	Updated policy to clarify Medicare Advantage section and direction
8 / 2024	Added definitions. Updated total time for codes 99202-99205, 99212-99215, 99306-99308

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP- 057		
Subject:	Evaluation & Management Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	April 22, 2024	**Revised Date:**	April 2024
Date Reviewed:	April 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

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PURPOSE:

This policy addresses the Plan's requirements (which may differ from CMS requirements) for selecting the level of a reported Evaluation and Management (E/M) service and the eligibility for E/M reimbursement based on the fulfillment of the required criteria.

REIMBURSEMENT GUIDELINES:

As of January 1, 2023, all Evaluation and Management services are now selected and scored based on medical decision-making (MDM) or time. Since January of 2021, this change has been in effect for New Patient or Other Outpatient Services, and Established Patient or Other Outpatient Services. Therefore, the following code sets will follow selecting the level of service based on Time or MDM:

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- Nursing Facility service codes (99304 - 99310, 99315, 99316)
- Home or Residence Service codes (99341, 99342, 99344, 99345, 99347 - 99350)

Note: Emergency Department codes (99281 - 99285) use only MDM to determine level of care.

Level based on Time

Time documentation criteria for time spent face-to-face or non-face-to-face may include, but 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

Note: Time spent by clinical staff, Patient wait time for physician or other health care providers, and additional distinct service procedures provided the same day as the evaluation and management service cannot be counted towards the selection of level of service based on time.

Level based on Medical Decision Making (MDM)

- 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: The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation but may be counted as ordered or reviewed for selecting an MDM level.

For purposes of the medical record audits of E/M coding levels, the Plan's position is that the complexity of the presenting complaint and medical decision making (MDM) should align with the complexity of the patient history and physical examination. Also, when determining the level of MDM, two of the three elements for that level must be met or exceeded.

New Patient Services

The Plan will no longer require the 3 components or reference face to face time when reporting New Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99202	Medically appropriate History and exam	Straightforward	15 - 29
99203	Medically appropriate History and exam	Low	30 - 44
99204	Medically appropriate History and exam	Moderate	45 - 59
99205	Medically appropriate History and exam	High	60 - 74

Established Patient Services

The Plan will no longer require 2 of 3 components or reference face to face time when reporting Established Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99211	Minimal problem that may not require the presence of a physician or other qualified health care professional	N/A	N/A
99212	Medically appropriate History and exam	Straightforward	10 - 19
99213	Medically appropriate History and exam	Low	20 - 29
99214	Medically appropriate History and exam	Moderate	30 - 39
99215	Medically appropriate History and exam	High	40 - 54

Non-Office E/M Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99221	Medically appropriate History and/or exam	Straightforward or Low	40 minutes must be met or exceeded
99222	Medically appropriate History and/or exam	Moderate	55 minutes must be met or exceeded
99223	Medically appropriate History and/or exam	High	75 minutes must be met or exceeded
99231	Medically appropriate History and/or exam	Straightforward or Low	25 minutes must be met or exceeded
99232	Medically appropriate History and/or exam	Moderate	35 minutes must be met or exceeded
99233	Medically appropriate History and/or exam	High	50 minutes must be met or exceeded
99234	Medically appropriate History and/or exam	Straightforward or Low	45 minutes must be met or exceeded
99235	Medically appropriate History and/or exam	Moderate	70 minutes must be met or exceeded
99236	Medically appropriate History and/or exam	High	85 minutes must be met or exceeded
99238	N/A	N/A	30 minutes or less
99239	N/A	N/A	More than 30 minutes

Nursing Facility Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES

99304	Medically appropriate History and/or exam	Straightforward or Low	25 minutes must be met or exceeded
99305	Medically appropriate History and/or exam	Moderate	35 minutes must be met or exceeded
99306	Medically appropriate History and/or exam	High	45 minutes must be met or exceeded
99307	Medically appropriate History and/or exam	Straightforward	10 minutes must be met or exceeded
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99309	Medically appropriate History and/or exam	Moderate	30 minutes must be met or exceeded
99310	Medically appropriate History and/or exam	High	45 minutes must be met or exceeded
99315	N/A	N/A	30 minutes or less
99316	N/A	N/A	More than 30 minutes

Home or Residence Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99341	Medically appropriate History and/or exam	Straightforward	15 minutes must be met or exceeded
99342	Medically appropriate History and/or exam	Low	30 minutes must be met or exceeded
99344	Medically appropriate History and/or exam	Moderate	60 minutes must be met or exceeded
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99347	Medically appropriate History and/or exam	Straightforward	20 minutes must be met or exceeded
99348	Medically appropriate History and/or exam	Low	30 minutes must be met or exceeded
99349	Medically appropriate History and/or exam	Moderate	40 minutes must be met or exceeded
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MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows Centers for Medicare and Medicaid Services (CMS) guidelines for Evaluation and Management services.

REFERENCES:

- *Medicare Claims Processing Manual*, Chapter 12; section 30.6.1: Selection of Level of Evaluation and Management Service Based on Duration of Coordination or Care and/or Counseling.

- American Medical Association; CPT® Evaluation and Management (E/M) Code and Guideline Changes

- Centers For Medicare and Medicaid Services; MLN Network: MLN 006764 January 2022

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- *Highmark Provider Manual*, Chapter 6; Unit 4: Selecting a Level of Medical Decision Making for Coding and Evaluation and Management Service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-020: Preventive Medicine and Office/Outpatient Evaluation and Management Services
- RP-037: Emergency Evaluation and Management Coding Guidelines

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Implementation
4 / 2021	Added note for G2211
11 / 2021	Added NY region applicable to the policy
5 / 2023	Updated with CMS 2023 changes to Evaluation and Management direction
1 / 2024	Updated note on Level Based on MDM and removed note for G2211
4 / 2024	Updated policy to clarify Medicare Advantage section and direction

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP- 057		
Subject:	Evaluation & Management Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	January 15, 2024	**Revised Date:**	January 2024
Date Reviewed:	January 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy addresses the Plan's requirements (which may differ from CMS requirements) for selecting the level of a reported Evaluation and Management (E/M) service and the eligibility for E/M reimbursement based on the fulfillment of the required criteria.

REIMBURSEMENT GUIDELINES:

As of January 1, 2023, all Evaluation and Management services are now selected and scored based on medical decision-making (MDM) or time. Since January of 2021, this change has been in effect for New Patient or Other Outpatient Services, and Established Patient or Other Outpatient Services. Therefore, the following code sets will follow selecting the level of service based on Time or MDM:

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- Home or Residence Service codes (99341, 99342, 99344, 99345, 99347 - 99350)

Note: Emergency Department codes (99281 - 99285) use only MDM to determine level of care.

Level based on Time

Time documentation criteria for time spent face-to-face or non-face-to-face may include, but 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

Note: Time spent by clinical staff, Patient wait time for physician or other health care providers, and additional distinct service procedures provided the same day as the evaluation and management service cannot be counted towards the selection of level of service based on time.

Level based on Medical Decision Making (MDM)

- 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: The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation but may be counted as ordered or reviewed for selecting an MDM level.

For purposes of the medical record audits of E/M coding levels, the Plan's position is that the complexity of the presenting complaint and medical decision making (MDM) should align with the complexity of the patient history and physical examination. Also, when determining the level of MDM, two of the three elements for that level must be met or exceeded.

New Patient Services

The Plan will no longer require the 3 components or reference face to face time when reporting New Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99202	Medically appropriate History and exam	Straightforward	15 - 29
99203	Medically appropriate History and exam	Low	30 - 44
99204	Medically appropriate History and exam	Moderate	45 - 59
99205	Medically appropriate History and exam	High	60 - 74

Established Patient Services

The Plan will no longer require 2 of 3 components or reference face to face time when reporting Established Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99211	Minimal problem that may not require the presence of a physician or other qualified health care professional	N/A	N/A
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99214	Medically appropriate History and exam	Moderate	30 - 39
99215	Medically appropriate History and exam	High	40 - 54

Non-Office E/M Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99221	Medically appropriate History and/or exam	Straightforward or Low	40 minutes must be met or exceeded
99222	Medically appropriate History and/or exam	Moderate	55 minutes must be met or exceeded
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99231	Medically appropriate History and/or exam	Straightforward or Low	25 minutes must be met or exceeded
99232	Medically appropriate History and/or exam	Moderate	35 minutes must be met or exceeded
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99236	Medically appropriate History and/or exam	High	85 minutes must be met or exceeded
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Nursing Facility Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES

99304	Medically appropriate History and/or exam	Straightforward or Low	25 minutes must be met or exceeded
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Home or Residence Services

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99350	Medically appropriate History and/or exam	High	60 minutes must be met or exceeded

Note: Medicare Advantage would follow CMS published guidelines.

REFERENCES:

- *Medicare Claims Processing Manual*, Chapter 12; section 30.6.1. Refer to Selection of Level of Evaluation and Management Service Based on Duration of Coordination or Care and/or Counseling.

- American Medical Association; CPT® Evaluation and Management (E/M) Code and Guideline Changes

- Centers For Medicare and Medicaid Services; MLN Network: MLN 006764 January 2022

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- *Highmark Provider Manual*, Chapter 6; Unit 4: Selecting a Level of Medical Decision Making for Coding and Evaluation and Management Service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-037: Emergency Evaluation and Management Coding Guidelines

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Implementation
4 / 2021	Added note for G2211
11 / 2021	Added NY region applicable to the policy
5 / 2023	Updated with CMS 2023 changes to Evaluation and Management direction
1 / 2024	Updated note on Level Based on MDM and removed note for G2211

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP- 057		
Subject:	Evaluation & Management Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	May 29, 2023	**Revised Date:**	May 2023
Date Reviewed:	January 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
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Applicable Claim Type	**UB**	☐	**1500**	☒			

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Level based on Medical Decision Making (MDM)

- 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: 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.

For purposes of the medical record audits of E/M coding levels, the Plan's position is that the complexity of the presenting complaint and medical decision making (MDM) should align with the complexity of the patient history and physical examination. Also, when determining the level of MDM, two of the three elements for that level must be met or exceeded.

New Patient Services

The Plan will no longer require the 3 components or reference face to face time when reporting New Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99202	Medically appropriate History and exam	Straightforward	15 - 29
99203	Medically appropriate History and exam	Low	30 - 44
99204	Medically appropriate History and exam	Moderate	45 - 59
99205	Medically appropriate History and exam	High	60 - 74

Established Patient Services

The Plan will no longer require 2 of 3 components or reference face to face time when reporting Established Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99211	Minimal problem that may not require the presence of a physician or other qualified health care professional	N/A	N/A
99212	Medically appropriate History and exam	Straightforward	10 - 19
99213	Medically appropriate History and exam	Low	20 - 29
99214	Medically appropriate History and exam	Moderate	30 - 39
99215	Medically appropriate History and exam	High	40 - 54

Non-Office E/M Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99221	Medically appropriate History and/or exam	Straightforward or Low	40 minutes must be met or exceeded
99222	Medically appropriate History and/or exam	Moderate	55 minutes must be met or exceeded
99223	Medically appropriate History and/or exam	High	75 minutes must be met or exceeded
99231	Medically appropriate History and/or exam	Straightforward or Low	25 minutes must be met or exceeded
99232	Medically appropriate History and/or exam	Moderate	35 minutes must be met or exceeded
99233	Medically appropriate History and/or exam	High	50 minutes must be met or exceeded
99234	Medically appropriate History and/or exam	Straightforward or Low	45 minutes must be met or exceeded
99235	Medically appropriate History and/or exam	Moderate	70 minutes must be met or exceeded
99236	Medically appropriate History and/or exam	High	85 minutes must be met or exceeded
99238	N/A	N/A	30 minutes or less
99239	N/A	N/A	More than 30 minutes

Nursing Facility Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99304	Medically appropriate History and/or exam	Straightforward or Low	25 minutes must be met or exceeded
99305	Medically appropriate History and/or exam	Moderate	35 minutes must be met or exceeded
99306	Medically appropriate History and/or exam	High	45 minutes must be met or exceeded
99307	Medically appropriate History and/or exam	Straightforward	10 minutes must be met or exceeded
99308	Medically appropriate History and/or exam	Low	15 minutes must be met or exceeded
99309	Medically appropriate History and/or exam	Moderate	30 minutes must be met or exceeded

99310	Medically appropriate History and/or exam	High	45 minutes must be met or exceeded
99315	N/A	N/A	30 minutes or less
99316	N/A	N/A	More than 30 minutes

Home or Residence Services

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99341	Medically appropriate History and/or exam	Straightforward	15 minutes must be met or exceeded
99342	Medically appropriate History and/or exam	Low	30 minutes must be met or exceeded
99344	Medically appropriate History and/or exam	Moderate	60 minutes must be met or exceeded
99345	Medically appropriate History and/or exam	High	75 minutes must be met or exceeded
99347	Medically appropriate History and/or exam	Straightforward	20 minutes must be met or exceeded
99348	Medically appropriate History and/or exam	Low	30 minutes must be met or exceeded
99349	Medically appropriate History and/or exam	Moderate	40 minutes must be met or exceeded
99350	Medically appropriate History and/or exam	High	60 minutes must be met or exceeded

Note: Medicare Advantage would follow CMS published guidelines.

Note: See Reimbursement Policy RP-041 for coverage status on related add-on code G2211 for visit complexity inherent to an evaluation and management service.

REFERENCES:

- *Medicare Claims Processing Manual*, Chapter 12; section 30.6.1. Refer to Selection of Level of Evaluation and Management Service Based on Duration of Coordination or Care and/or Counseling.
- American Medical Association; CPT® Evaluation and Management (E/M) Code and Guideline Changes
- Centers For Medicare and Medicaid Services; MLN Network: MLN 006764 January 2022

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- *Highmark Provider Manual*, Chapter 6; Unit 4: Selecting a Level of Medical Decision Making for Coding and Evaluation and Management Service.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-037: Emergency Evaluation and Management Coding Guidelines
- RP-041: Services Not Separately Reimbursed

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Implementation
4 / 2021	Added note for G2211
11 / 2021	Added NY region applicable to the policy
5 / 2023	Updated with CMS 2023 changes to Evaluation and Management direction

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-057		
Subject:	Evaluation & Management Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) published evaluation and management (E/M) documentation guidelines in 1995 and 1997. The Plan allows providers to use either set of these guidelines, however, the provider shall not mix the two sets of guidelines for a single encounter. This policy addresses The Plan's requirements (which may differ from CMS requirements) for selecting the level of a reported E/M service and the eligibility for E/M reimbursement based on the fulfillment of the required criteria.

REIMBURSEMENT GUIDELINES:

CPT guidelines do not specify which two out of the three key components must meet or exceed the stated requirements to qualify for reporting a particular level of E/M for new and established patient visits, the Plan's position is the complexity of the presenting complaint and medical decision making (MDM) should align with the complexity of the patient history and physical examination.

For purposes of the medical record audits of E/M coding levels, the Plan expects the medical records will reflect the MDM component is aligned with the complexity of the patient history and examination. The Plan considers MDM as one of the key parameters in determining whether up coding has occurred when auditing E/M services. This position is based on the Plan's interpretation of the 1995 and/or 1997 E/M documentation guidelines found in the Medicare Claims Processing Manual, Chapter 12; section 30.6.1.

The American Medical Association (AMA) and (CMS) have established revisions to office and outpatient visit codes.

- New Patient or Other Outpatient Services code range: 99202 - 99205
- Established Patient or Other Outpatient Services code range: 99211 - 99215

New Patient Services

The Plan will no longer require the 3 components or reference face to face time when reporting New Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99202	Medically appropriate History and exam	Straightforward	15 - 29
99203	Medically appropriate History and exam	Low	30 - 44
99204	Medically appropriate History and exam	Moderate	45 - 59
99205	Medically appropriate History and exam	High	60 - 74

Established Patient Services

The Plan will no longer require 2 of 3 components or reference face to face time when reporting Established Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

CODE	MEDICAL EXAM	MEDICAL DECISION MAKING	TOTAL MINUTES
99211	Minimal problem that may not require the presence of a physician or other qualified health care professional	N/A	N/A
99212	Medically appropriate History and exam	Straightforward	10 - 19
99213	Medically appropriate History and exam	Low	20 - 29
99214	Medically appropriate History and exam	Moderate	30 - 39
99215	Medically appropriate History and exam	High	40 - 54

Note: See Reimbursement Policy RP-041 for coverage status on related add-on code G2211 for visit complexity inherent to an evaluation and management service.

Note: Medicare Advantage would follow CMS published guidelines.

REFERENCES:

- *Medicare Claims Processing Manual*, Chapter 12; section 30.6.1. Refer to Selection of Level of Evaluation and Management Service Based on Duration of Coordination or Care and/or Counseling.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- *Highmark Provider Manual*, Chapter 6; Unit 4: Selecting a Level of Medical Decision Making for Coding and Evaluation and Management Service.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Implementation
4 / 2021	Added note for G2211
11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-057		
Subject:	Evaluation & Management Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	April 5, 2021	**Revised Date:** April 2021	
Date Reviewed:	March 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐		
Applicable Claim Type	**UB**	☐	**1500**	☒		

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For purposes of the medical record audits of E/M coding levels, the Plan expects the medical records will reflect the MDM component is aligned with the complexity of the patient history and examination. The Plan considers MDM as one of the key parameters in determining whether up coding has occurred when auditing E/M services. This position is based on the Plan's interpretation of the 1995 and/or 1997 E/M documentation guidelines found in the Medicare Claims Processing Manual, Chapter 12; section 30.6.1.

The American Medical Association (AMA) and (CMS) have established revisions to office and outpatient visit codes.

- New Patient or Other Outpatient Services code range: 99202-99205
- Established Patient or Other Outpatient Services code range: 99211-99215

New Patient Services

The Plan will no longer require the 3 components or reference face to face time when reporting New Patient Services. Each service must include a medically appropriate history and/or examination, the code selection will be based on the (MDM) level or time spent with the patient for that date of service.

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99202	Medically appropriate History and exam	Straightforward	15-29
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Note: See Reimbursement Policy RP-041 for coverage status on related add on code G2211 for visit complexity inherent to an evaluation and management service.

Note: Medicare Advantage would follow CMS published guidelines.

ADDITIONAL BILLING INFORMATION, REFERENCES, AND GUIDELINES:

- *Medicare Claims Processing Manual*, Chapter 12; section 30.6.1. Refer to Selection of Level of Evaluation and Management Service Based on Duration of Coordination or Care and/or Counseling.
- *Highmark Provider Manual*, Chapter 6; Unit 4: Selecting a Level of Medical Decision Making for Coding and Evaluation and Management Service.
- RP-041 *Services Not Separately Reimbursed.*

POLICY UPDATE HISTORY INFORMATION:

01 / 2021	Implementation
04 / 2021	Added note for G2211

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-057		
Subject:	Evaluation & Management Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	November 1, 2020	**Revised Date:**	
Date Reviewed:			
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
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99211	Minimal problem that may not require the presence of a physician or other qualified health care professional	N/A	N/A
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ADDITIONAL BILLING INFORMATION, REFERENCES, AND GUIDELINES:

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- *Highmark Provider Manual*, Chapter 6; Unit 4: Selecting a Level of Medical Decision Making for Coding and Evaluation and Management Service.
- RP-041 *Services Not Separately Reimbursed.*

POLICY UPDATE HISTORY INFORMATION:

01 / 2021	Implementation