Evaluation and Management

Payment policy

MASSACHUSETTS

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted providers for covered, medically necessary, evaluation and management (E/M) services.

General benefit information

Covered services and payment are based on the member's benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members' costs depend on member benefits.

Certain services require prior authorization or referral.

Payment information

Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

Blue Cross reimburses:

- **Commercial products only:** Consistent with 2023 AMA rules for initial hospital inpatient or observation care (99221-99223), we will reimburse one initial hospital or observation care code to providers with the same specialty and federal tax id number per stay. A transition from observation level to inpatient does not constitute a new stay.
- Subsequent services must be billed with the applicable subsequent hospital inpatient and observation care codes (99231-99233) or inpatient or observation consultation codes (99251-99254) when CPT requirements for consultation have been met.
- New patient visit codes once every three years by the same provider or another physician in the same group with the same specialty who has not seen the patient in three years. Blue Cross uses the new patient definition consistent with CMS and defines a new patient as one who has not received any professional services, that is, E/M service or other face-to-face service (example: surgical procedure) from the physician or other qualified health professional or physician group practice (same physician specialty) within the previous three years. The interpretation of a diagnostic test or x-ray is not considered a face-to-face service. A new patient E/M code billed after a non-face-to-face service will be accepted as a new patient visit as long as no other face-to-face services were billed within the previous three years.
    - If a patient follows their provider to a new practice, this is not considered a new patient unless three years have passed since the last visit.
- Established patient visits.
- Preventive medicine E/M visit codes for a new or established patient.
- Emergency department visit codes when rendered at a hospital for unscheduled care requiring immediate attention.
- Adult, pediatric, and neonatal critical care codes.
    - Reimbursement is inclusive but not limited to the CPT definition of these codes.
    - Services rendered in a critical care setting to a non-critical patient will be reimbursed using the appropriate E/M code.
- One E/M code per member per date of service per provider with the same specialty and group regardless of the place of service.
    - An additional E/M service may be reimbursed when reported by a provider with a different specialty or board certification. Documentation must support the nature of the services.
    - A preventive medicine, annual wellness or problem-focused visit on the same day by the same provider will be reimbursed at 100% for the highest allowable service and 50% for all other separately identifiable visit codes.
- Same day evaluation and management service with global day procedure.
    - When a distinct, separately identifiable new or established patient evaluation and management service (99202-99205 or 99211-99215) is provided at the same session on the same day as a service that has a CMS global period indicator of 0, 10, 90 days, the lesser allowable service will be reimbursed at 50% of the fee schedule allowable. The higher allowable service will continue to be reimbursed at 100% of the fee schedule allowable.

    - Effective January 1, 2023, this policy applies to preventative evaluation and management codes (99381-99397, G0402, G0438, and G0439). This policy does not apply to the following specialties: chiropractic and acupuncture.
- Telehealth (telemedicine) services as defined by the Telehealth (Telemedicine) – Medical and Telehealth (Telemedicine) – Behavioral Health payment policies.
- Transitional care management services.
    - Includes services from discharge day to 29 days post discharge.
- Chronic care management services and complex chronic care management.
- Principal care management services.
- Split/shared E/M's when reported with modifier FS by the provider preforming the substantive portion of the visit.
    - May only be reported in a facility setting.
    - Blue Cross follows CMS rules for reporting these services, the definition of substantive services, and the documentation requirements.

Blue Cross does not reimburse:
- Office consultation codes and inpatient or observation consultation code, 99255.
- An initial preventive visit billed with a new patient sick visit code.
- E/M services billed within the defined global period of a surgical service by the same provider.
- Prolonged service codes.
- Venipuncture when reported with an E/M service.
- Handling and or conveyance fees.
- E/M services reported the same day as chemotherapy, unless there is a separately identifiable E/M service and is reported as such with the appropriate modifier.
- Limited ultrasound codes reported with an E/M service, unless the service is separate and distinct.
- Medical team conference services.
- Medical testimony.
- Online E/M services.
- Preventive medicine counseling or risk factor reduction services provided to a group.
- Administration of a health risk assessment.
- Adult vaccine administration codes when reported with an E/M service.
- Resource intensive services for patients for whom the use of specialized mobility-assistive technology is used during an office visit.
- Cervical or vaginal cancer screening; pelvic and clinical breast examination when reported with a preventive E/M code.
- Prostate cancer screening or digital rectal examination when reported with a preventive E/M code.
- Screening Papanicolaou (pap) smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory when reported with a preventive E/M code.
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated/non-automated, without microscopy.
- Effective May 1, 2023 Medicare annual wellness exams are not reimbursed for commercial claims

General reimbursement information
Blue Cross recognizes the Centers for Medicare & Medicaid Services (CMS) 1995 and 1997 documentation guidelines for selecting E/M services and the CMS 2019 simplification of documentation guidelines for history, chief complaint and physical exams for office/outpatient visits.
- 1995 guidelines: **cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf**
- 1997 guidelines: **cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf**

Medical necessity is the primary criterion for payment, in addition to the individual requirements of a CPT®″ code. It is neither medically necessary nor appropriate to bill a higher level of E/M service when a lower level of service is warranted. Volume of documentation should not be the primary influence upon which a specific level of service is billed. The reason for the visit must medically support the extent of the exam and discussion time noted and must be consistent with the complexity appropriate to the reason for the visit or assessment.

Blue Cross recognizes the 2023 AMA code selection and reporting guidelines for hospital inpatient or observation care services, consultation codes, emergency department services codes, nursing facility codes, and home or residence code services.

Blue Cross recognizes the 2021 AMA code selection guidelines for outpatient office visit codes, 99202-99215.

- If time is the basis for the outpatient E/M code selection, the time spent must be documented in the medical record.
    - Time includes face-to-face and non- face to- face time for the following elements:
        - Preparing to see the patient (e.g., review of tests)
        - Obtaining and/or reviewing separately obtained history
        - Performance of a medically appropriate exam and or evaluation
        - Counseling and education to patient, family or care giver
        - Ordering medications, tests or procedures
        - Referring and communicating with other health professionals (when not separately reported)
        - Documenting clinical information in the medical record
        - Independently interpreting results (not separately reported) and communicating results
        - Care coordination (not separately reported)

Billing information

Specific billing guidelines

Please note, the absence or presence of a procedure code or service does not imply or guarantee coverage or reimbursement.

- The submission of modifier 25 appended to a procedure code indicates that documentation is available in the patient's records which will support the distinct, significant, separately identifiable nature of the evaluation and management service submitted with modifier 25, and that these records will be provided in a timely manner for review upon request.
- If both preventive and problem-oriented visits are provided to a new patient (as defined above), bill the preventive service with the age-appropriate new patient CPT code, and the problem-oriented visit as established patient visit.
- All surgical procedures and some non-surgical procedural services include a certain degree of physician involvement or supervision, pre-service work, and post-service work which is integral to that service. For those procedures and services, a separate E/M service is not normally reimbursed.
- By assigning a global day indicator of "000" or "010," CMS is indicating that the RVU for the procedure includes reimbursement for the assessment of the problem, and:
    - determining that the procedure is necessary,
    - evaluating whether the procedure is appropriate, and the patient is a good candidate,
    - discussing the risks and benefits,
    - obtaining informed consent, and
    - performing the procedure.
- To support reporting a separate E/M with modifier 25, the evaluation must extend beyond what will be treated by the procedure.

Correct use of modifier 25:

An established patient is seen in the office for a follow-up of their diabetes. While there, the patient asks the provider to address a new issue of left hip pain. The physician:

- Performed a problem-focused history and exam of the patient's hypertension and diabetes and changed the patient's medications.
- Evaluated the hip and performed an injection/arthrocentesis.

Bill 99212-25 and 20610. The evaluation of the hip problem is included in CPT 20610. The patient was seen for a problem other than the hip, necessitating an E/M service.

Incorrect use of modifier 25:

A patient sees the doctor with a complaint of multiple skin lesions in the neck and axilla area which are causing discomfort from itching and bleeding.

- The physician recommends removal of the lesions. Twenty lesions are removed.

Bill 11200 only. No E/M with modifier 25 is reported. The use of modifier 25 is not appropriate because the E/M service did not go above and beyond the usual preoperative service. Also, since CPT 11200 has a global period of 010 days, the decision

for surgery E/M service on the same date of service as the minor surgical procedure is not eligible to be reported with modifier 57. It is included in the payment for the surgical procedure.

Do not report modifier 59, XE, XP, XS, or XU on an E/M service.

- If the patient is seen elsewhere and admitted to the hospital, all services at the original visit and care at the hospital are included in the initial hospital E/M service. Two E/M's are not reported.

Code	Service description	Comments
99202- 99499	Evaluation and management codes	
New patient codes		
99202-99205	Office or other outpatient evaluation and management services for a new patient	Reimbursed once every three years for same provider/or same group with same specialty. Subject to payment reduction associated with a preventive and well visit on the same day.
99381-99387	Initial comprehensive preventive medicine evaluation and management visits	
Established patient visit codes		
99211-99215	Established patient sick visits	Subject to payment reduction associated with a preventive and well visit on the same day.
99391-99397	Periodic comprehensive preventive medicine re-evaluation and management visits	
Emergency department visit codes		
99281-99285	Emergency department visit codes	
Initial hospital care codes		
99221-99223	Initial hospital inpatient or observation care per day	**Effective** 1/1/2023 for commercial products: Reimbursed once per stay for the same provider or providers in the same group with the same specialty **Prior** to 1/1/2023 for commercial products: Reimbursed once per admission for the admitting physician regardless of specialty or group.
Subsequent hospital care codes		
99231-99233	Subsequent hospital or observation care per day	**Effective** 1/1/2023: Used to report subsequent encounters from initial hospital care or consultations. **Prior** to 1/1/2023: May be used to bill for initial inpatient hospital services from other than the admitting physician.
99238-99239	Hospital inpatient or observation discharge day management	May only be billed by the attending physician of record or physician acting on behalf of the physician of record. Bill when discharge date is different than admission date. Time spent includes total duration of time spent with the patient that day, even if not continuous. May only be billed once per inpatient stay regardless of specialty or group.
Inpatient consultation codes		
99252-99254	Inpatient or observation consultation for new or established patient; 35-60 minutes must be met or exceeded at the bedside	For commercial products, a consult code may be reported once per admission per consultant per same specialty and group when CPT requirements for consultation have been met. Follow-up visits are

Code	Service description	Comments
		reported using the subsequent inpatient hospital or observation care E/M codes. For commercial claims, may be used to bill for initial inpatient hospital or observation services if CPT requirements for consultation are met. **Effective** 1/1/2023: When using total time on the date of the encounter for code selection, the applicable minutes based on the code must be met or exceeded.
99255	Inpatient hospital or observation consultation for new or established patient; typically, 110 minutes at bedside	Not reimbursed.
Critical care visit codes		
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	Reimbursed for one unit only.
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary service)	Must be reported with 99291. See time limits in Billing Scenarios below.
99468- 99469	Initial or subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	Report for critically ill neonate 28 days of age or younger.
99471-99472	Initial or subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Report for a critically ill infant or young child from 29 days old to 24 months old. 99471 – May be billed by only one physician, one time per day.
99475-99476	Initial or subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	Report for critically ill young child ages 2 through 5 years old. 99475 - May be billed by only one physician, one time per day.
Principal Care		
99424-99427	Principal care management services, for a single high-risk disease	99425 and 99427 must be reported with primary procedure.
Transitional care		
99495-99496	Transitional care management services	
Chronic care management		
99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	Must be reported with primary procedure.
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other	Must be reported with primary procedure.

Code	Service description	Comments
	qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	
99487, 99489	Complex chronic care management services	Reported per calendar month when time requirements are met.
99437, 99439, 99490, 99491	Chronic care management services	Reported per calendar month when time requirements are met. 99437 and 99439 must be reported in addition to the primary procedure code.
Initial preventive and annual wellness visit (Medicare)		
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	These codes are subject to payment reduction associated with a preventive and well visit on the same day. Effective May 1, 2023 G0438 and G0439 are not reimbursed for commercial claims
G0438-G0439	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit and subsequent visit	
Consultation codes		
99242-99245; 99255	Office and inpatient hospital or observation consultation visit codes	Not reimbursed. Use appropriate E/M visit code.
G2213	Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services	Must be reported with primary procedure. Services must be performed in the Emergency Department.
Prolonged service and visit complexity codes		
99358-99359	Prolonged service codes	Not reimbursed with an E/M service code.
99415-99416	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision	Not reimbursed.
99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (list separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	Not reimbursed.
99418	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)	Not reimbursed
G0316	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using 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	Not reimbursed
G0317	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service	

Code	Service description	Comments
	(when the primary service has been selected using 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	
G0318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using 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	Not reimbursed
G0513-G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service	Not reimbursed.
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	Not reimbursed.
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	Not reimbursed.
Medical team conference codes		
99366-99368	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family/patient and family not present by physician/non-physician	Not reimbursed.
Preventive medicine group counseling		
99411-99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting	Not reimbursed.
Other non-reimbursed services		
36415	Collection of venous blood by venipuncture	Not separately reimbursed with an E/M service code or blood lab code.
36416	Collection of capillary blood specimen	Not reimbursed.
76705	Ultrasound, abdominal, real time with image documentation; limited (example: single organ, quadrant, follow-up)	Not separately reimbursed when reported with an E/M service code.
76775	Ultrasound, retroperitoneal (examples: renal, aorta, nodes), real time with image documentation; limited	
76857	Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up (examples: for follicles)	
76882	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (e.g., joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation	

Code	Service description	Comments
81002, 81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated/ non-automated, without microscopy	Not reimbursed when reported with an E/M code.
99000, 99001, 99002	Handling and or conveyance fees	Not reimbursed.
90471-90474	Vaccine administration codes	Not reimbursed separately when reported with an office visit for members who are 20 years or older.
G0008	Administration of influenza virus vaccine	Not reimbursed separately when reported with an office visit for members who are 20 years or older.
G0009	Administration of pneumococcal vaccine	
G0010	Administration of hepatitis B vaccine	
96160	Administration of a patient focused health risk assessment instrument (example: depression inventory) for the benefit of the patient, with scoring and documentation, per standard instrument	Reimbursed under the Healthy Actions program only.
96161	Administration of caregiver-focused health risk assessment instrument (example: depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	Not reimbursed.
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Not reimbursed.
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Not reimbursed.
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Not reimbursed.
99071	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	Not reimbursed.
99075	Medical testimony	
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (example: prenatal, obesity, or diabetic instructions)	
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	
99082	Unusual travel (example: transportation and escort of patient)	
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Not reimbursed when reported with 99381-99397.
G0102	Prostate cancer screening; digital rectal examination	
G0501	Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient,	Not reimbursed.

Code	Service description	Comments
	evaluation and management visit (list separately in addition to primary service)	
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	Not reimbursed when reported with 99381-99397.
Modifiers		
FS	Split (or shared) evaluation and management visit	

Billing and coding scenarios

Preventive and sick visit separately reported:
Determining if you report a problem-focused service or "sick visit" in addition to a preventive service is dependent upon the nature of the patient's problems and the associated documentation. The CPT® codebook instructs, "If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office/outpatient code 99202-99215 should also be reported."

Documentation must support both services. If any portion of the history or exam was performed to satisfy the preventive service, that same portion of work **may not be used** to calculate the additional level of E/M service. A *separate* history of present illness (HPI), describing the patient's complaint, supports additional work in the history (there's no HPI for a preventive service). If a portion of the exam performed is not routine for a preventive service, clearly identify that portion.

Remember: When selecting the additional E/M level of service, only the work "above and beyond" what would have been performed during the preventive service may be counted toward the problem-focused visit.

Example:
A four-year-old child arrives for an annual check-up. The provider notices the child has significant wheezing and shortness of breath. A chest X-ray is ordered, and a nebulizer treatment is performed.
- Bill 99392 (preventive visit for an established patient ages 1-4) with an appropriate sick visit code and modifier 25.

Preventive with a non-reportable sick visit
A 12-month child arrives for an annual check-up. The provider notices a diaper rash and provides an ointment.
- Bill only the preventive visit, 99392 (preventive visit for an established patient ages 1-4).

Critical care services
Use **99291** (critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes) and **99292** (each additional 30 minutes).

For	Bill
Less than 30 minutes	Appropriate E/M code
30-74 minutes	99291 x 1
75-104 minutes	99291 x 1 and 99292 x 1
105-134 minutes	99291 x 1 and 99292 x 2
135-164 minutes	99291 x 1 and 99292 x 3
165-194 minutes	99291 x 1 and 99292 x 4

Examples:
Patient A receives a total of 100 minutes of critical care services in the course of a day.
- Bill 99291 and one unit of 99292.

Patient B receives a total of 70 minutes of critical care services in the course of a day.

- Bill only 99291. The time requirement is not met for coding 99292.

Effective 1/1/2023: Initial hospital inpatient or observation care
Initial hospital or observation care codes may only be reported once per admission by the same provider or providers with the same specialty in the same group. Further inpatient or observation care services are reported with inpatient or observation subsequent care codes.

Example 1/1/2023 and after:
- Dr. A, an internist, admits a patient to the hospital with severe pneumonia and performs the initial work-up and assessment on 1/15/2023. Dr. B, a pulmonologist, from the same group is asked to see the patient on the same day.
- Dr. A bills hospital inpatient or observation care code as appropriate (99221-99223).
- Dr. B bills either an initial hospital or observation care code, 99221-99223, or consultation code if appropriate, and criteria are met, 99252-99254.
- Both Dr. A and B see the patient on 1/16/2023. Both report a subsequent care code, 99231-99233.

Example prior to 1/1/2023:
- Dr. A, an internist, admits a patient to the hospital with severe pneumonia and performs the initial work-up and assessment on 12/1/2022. Dr. B, a pulmonologist, is asked to see the patient on the same day.
- Dr. A bills inpatient hospital care code as appropriate, 99221-99223.
- Dr. B bills an inpatient consultation code if consultation criteria are met (99251-4) or subsequent hospital care codes (99231-99233).

When submitting claims for reimbursement, report all services with:
- Up-to-date industry-standard procedure and diagnosis codes
- Modifiers that affect payment in the first modifier field, followed by informational modifiers

Related policies

Note: Log into Provider Central before clicking Payment Policy links.

After-Hours and Weekend Care Services
CPT and HCPCS Modifiers
Frequency
General Coding and Billing
Immunizations
Laboratory and Pathology
Non-Reimbursable Services
Surgery-Professional
Telehealth (Telemedicine) – Medical Services
Telehealth (Telemedicine) – Mental Health
Medical Policies

Document history

08/01/2012	Documentation of existing policy.
04/30/2013	Revision of document to clarify situations in which Blue Cross may reimburse for multiple E/M services; description of change to policy for radiology professional component when performed with E/M service; documentation of policy on limited ultrasound when performed with E/M service.
01/15/2014	Template update.
03/12/2015	Annual review, template update, documentation of Blue Cross's existing policy on E/M and chemotherapy services; documentation of Blue Cross's existing policy on telephone services.
10/01/2015	Template update, inclusion of "Related Policies" section.
03/31/2016	Annual review; template update; inclusion of detailed information on existing policy on reimbursable and non-reimbursable services and specific billing guidelines; removal of description of policy for radiology professional component when performed with E/M service.
01/01/2017	Annual review; template update; inclusion of updated CPT coding information; inclusion of detailed information on reimbursement guidelines for screening services effective March 1, 2017.

03/08/2017	Inclusion of information on reimbursement guidelines for 96160 under the Healthy Actions program.
01/01/2018	Annual coding update; addition of HCPCS codes G0513, G0514.
07/15/2018	Annual review; template updates; clarification code range for prolonged service codes; addition of coding for emergency department services telephone internet services, annual wellness codes, vaccine administration codes information and billing scenarios; expanded billing guidelines for E/M visits and modifier 25; added urinalysis payment information; added link to 95/97 E/M documentation guidelines
12/31/2018	Annual coding update; addition of CPT codes 99451 and 99452; revision of descriptor of CPT codes 99446-9
06/30/2019	Annual review; template update; inclusion of chronic care management to reimbursed services; inclusion of 36416 and 99000-2 to non-reimbursement info to coding grid; added simplification of documentation guidelines; added billing guidelines for reporting a new patient preventive visit with a new patient sick visit; clarified multiple E/M reporting; added After-Hours and Weekend Care to related policies
12/31/2019	Updated preventive and problem E/M reimbursement effective 4/1/2020; updated same day evaluation and management service with global day procedure effective 4/1/2020; annual coding review; added 99421-99423 and 98970-98972, G2061-G2063, deleted 99444
03/26/2020	Removed same day E/M with global procedure rule announcement for temporary delay in implementation; added reference to Telehealth policy for 98970-2 and G2061-3
09/01/2020	Annual review; expanded codes in coding grid; expanded new patient information; addition of initial hospital care and inpatient consultation, and complex care management codes, updated coding instructions for codes
12/01/2020	Addition of reimbursement information for same day evaluation and management service with global day procedure effective 3/1/2021
12/23/2020	Annual coding update, revised EM range to remove 99201, added codes 99417 and 99439 in coding grid, updated code description for 99415 and 99416.; added G2211, G2212 and G2213
01/13/2021	Removes end dated codes: G2061, G2062, G2063 and G2211; updated effective date for initial hospital care rule to 4/1/2021
06/30/2021	Annual review; added E/M time determinate information; added G2211 as not reimbursed; added Frequency as a related policy
12/31/2021	Annual coding update; addition of new principal care and chronic care management codes; Modifier FS added
06/30/2022	Annual review; clarified new patient definition when provider changes practice; added FS modifier POS information; added services included in transitional care; included complex chronic care services as reimbursed; Removed 99421-3, 99446-9,99451-2 from coding grid
09/29/2022	Updated to include reimbursement policy update effective January 1, 2023: same-day evaluation and management (E/M) service with global day procedure policy to include preventative medicine E/M service codes.
12/31/2022	Annual coding update, revised hospital inpatient or observation code and consultation code descriptors and CPT 76882; revised initial hospital or observation reporting instructions and billing example; removed deleted codes 99241, 99251, 99354-7, addition of CPT 99418 and HCPCS G0316-G0318 as not reimbursed
02/01/2023	Updated G0438 and G0439 reimbursement for commercial claims only

Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider's contract(s);

scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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