Provider Payment Guidelines

Evaluation and Management Services

Policy

Mass General Brigham Health Plan reimburses participating providers for the provision of medically necessary evaluation and management (E/M) services, including specialist visits and second opinions.

Mass General Brigham Health Plan follows the CMS 1995/1997 and AMA 2021 documentation guidelines for E/M services. Medical records must support reported levels of services based on these guidelines. Please reference the most current version of the American Medical Association (AMA) CPT-4 Manual for complete descriptors of E/M codes and instructions for selecting a level of service.

Reimbursement

Providers are reimbursed according to the plan’s network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member’s benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider’s agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member’s benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global
allowance, are not eligible for separate reimbursement. Please refer to General Coding and Billing for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Mass General Brigham Health Plan reimbursement is based online of business.

Mass General Brigham Health Plan Does Not Reimburse

Note: This list may not be all-inclusive and is subject to change

- Adjunct codes reported in addition to the basic service rendered, including codes for medical services provided from 10:00pm to 8:00am at a 24-hour facility; or out-of-the-office; or on an emergency basis out-of-the-office
- An emergency department E/M service billed with critical care services rendered by the same provider on the same date of service or telehealth consultation
- Consultation codes (99241-99245, 99251-99255)
- E/M services within the global period of a procedure
- Established patient E/M services on the same day as a surgical procedure unless there is a significant, separately identifiable E/M service appended with the appropriate modifier
- Generic and/or special supplies
- Handling fees
- Inpatient consultations (99221-99223, 99231-99233) when the consulting provider is not face-to-face with the patient in the facility
- Medical testimony, special reports or forms, or computer data analysis
- Out of hospital on-call services
- Services identified by CPT as included in the descriptor as pediatric critical care services
- Unusual physician travel

Procedure Codes

Note: This list of codes may not be all-inclusive

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Short Descriptor</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>36415</td>
<td>Routine blood draw</td>
<td>Not separately reimbursable when billed with laboratory or E/M codes</td>
</tr>
<tr>
<td>36416</td>
<td>Collection of capillary blood specimen</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>Code(s)</td>
<td>Short Descriptor</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>96040</td>
<td>Genetic counseling services; 30 minutes</td>
<td></td>
</tr>
<tr>
<td>99000-99002</td>
<td>Specimen handling</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99024</td>
<td>Post-operative follow-up visit</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99026-99027</td>
<td>Hospital mandated on call service</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99050</td>
<td>Services provided in the office at times other than regularly scheduled business hours, or days when the office is normally closed; in addition to basic service</td>
<td>Report in conjunction with designated E/M level visit; not reimbursable for Urgent Care Centers or when billed with telemedicine visits</td>
</tr>
<tr>
<td>99051</td>
<td>Services provided in the office during regularly scheduled evening, weekend, or holiday office hours; in addition to basic service</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99053</td>
<td>Services provided between 10:00PM and 8:00AM at 24-hour facility; in addition to basic service</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99056</td>
<td>Services typically provided in the office, provided out of the office at request of the patient; in addition to basic service</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99058</td>
<td>Office emergency care which disrupts other scheduled office visits</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99060</td>
<td>Services provided on an emergency basis, out of the office, which disrupts other scheduled office services; in addition to basic service</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99070</td>
<td>Supplies and materials provided by the physician</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99075</td>
<td>Medical testimony</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99080</td>
<td>Special reports or forms</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99082</td>
<td>Unusual travel</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99090</td>
<td>Computer data analysis</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99173</td>
<td>Visual acuity screening test</td>
<td>Not separately reimbursable when billed with E/M codes</td>
</tr>
<tr>
<td>92202-99205</td>
<td>Office or other outpatient visit; new patient</td>
<td></td>
</tr>
<tr>
<td>99211-99215</td>
<td>Office or other outpatient visit; established patient</td>
<td></td>
</tr>
</tbody>
</table>
## Evaluation and Management Services

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Short Descriptor</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221-99223</td>
<td>Inpatient or Observation services; initial care</td>
<td>Please refer to <a href="#">Inpatient Hospital Admissions</a></td>
</tr>
<tr>
<td>99231-99233</td>
<td>Inpatient or Observation services; subsequent care</td>
<td></td>
</tr>
<tr>
<td>99234-99236</td>
<td>Inpatient hospital or Observation care</td>
<td></td>
</tr>
<tr>
<td>99238-99239</td>
<td>Hospital Inpatient or Observation discharge services</td>
<td></td>
</tr>
<tr>
<td>99242-99245</td>
<td>Office consultations</td>
<td>Not reimbursable; report with appropriate complexity level office visit E/M code. For MassHealth claims, refer to <a href="#">MassHealth Transmittal Letter AOH-56</a></td>
</tr>
<tr>
<td>99252-99255</td>
<td>Inpatient or Observation consultations</td>
<td>Not reimbursable; report with appropriate complexity level hospital inpatient E/M code</td>
</tr>
<tr>
<td>99281-99285</td>
<td>Emergency department services</td>
<td></td>
</tr>
<tr>
<td>99288</td>
<td>Physician direction of advanced life support</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>99291-99292</td>
<td>Critical care services</td>
<td>Report initial service (30-74 minutes) with CPT code 99291 with a count of one unit. Report each additional 30 minutes as one unit using CPT 99292.</td>
</tr>
<tr>
<td>99304-99306</td>
<td>Nursing facility services; initial</td>
<td></td>
</tr>
<tr>
<td>99307-99310</td>
<td>Nursing facility services; subsequent</td>
<td></td>
</tr>
<tr>
<td>99315-99316</td>
<td>Nursing facility discharge services</td>
<td></td>
</tr>
<tr>
<td>99341-99345</td>
<td>Physician home services; new patient</td>
<td></td>
</tr>
<tr>
<td>99347-99350</td>
<td>Physician home services; established patient</td>
<td></td>
</tr>
<tr>
<td>99358-99359</td>
<td>Prolonged services without direct patient contact</td>
<td></td>
</tr>
<tr>
<td>99360</td>
<td>Standby services</td>
<td>Not reimbursable</td>
</tr>
</tbody>
</table>
### Provider Payment Guidelines

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Short Descriptor</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>93792-93793</td>
<td>Anticoagulation management services</td>
<td>Report for outpatient management services only. Do not report in conjunction with an E/M or care plan oversight code for this service.</td>
</tr>
<tr>
<td>99366</td>
<td>Medical team conference; direct contact</td>
<td>Not covered</td>
</tr>
<tr>
<td>99374-99380</td>
<td>Care plan oversight services</td>
<td></td>
</tr>
<tr>
<td>99381-99387</td>
<td>Preventive medicine services; new patient</td>
<td></td>
</tr>
<tr>
<td>99391-99397</td>
<td>Preventive medicine services; established patient</td>
<td></td>
</tr>
<tr>
<td>99401-99404</td>
<td>Preventive medicine counseling</td>
<td></td>
</tr>
<tr>
<td>99406-99409</td>
<td>Behavior change interventions</td>
<td></td>
</tr>
<tr>
<td>99411-99412</td>
<td>Preventive medicine group counseling</td>
<td></td>
</tr>
<tr>
<td>99417-99418</td>
<td>Prolonged care, each 15 minutes</td>
<td></td>
</tr>
<tr>
<td>99429</td>
<td>Unlisted preventive service</td>
<td>Not reimbursable; submit with appropriate evaluation and management code</td>
</tr>
<tr>
<td>99441-99443</td>
<td>Telephone services; non-face-to-face</td>
<td></td>
</tr>
<tr>
<td>99421-99423</td>
<td>Online medical evaluation</td>
<td></td>
</tr>
<tr>
<td>99466-99467;</td>
<td>Pediatric critical care during the inter-facility</td>
<td>Please refer to <a href="#">Newborn Care Payment Policy</a></td>
</tr>
<tr>
<td>99485-99486</td>
<td>transport</td>
<td></td>
</tr>
<tr>
<td>99468-99469</td>
<td>Neonatal critical care age &lt;28 days</td>
<td>Please refer to <a href="#">Newborn Care Payment Policy</a></td>
</tr>
<tr>
<td>99471-99472</td>
<td>Pediatric critical care, age 29 days through 24 months</td>
<td>Please refer to <a href="#">Newborn Care Payment Policy</a></td>
</tr>
<tr>
<td>99475-99476</td>
<td>Pediatric critical care, age 2-5 years</td>
<td>Please refer to <a href="#">Newborn Care Payment Policy</a></td>
</tr>
<tr>
<td>99492-99494</td>
<td>Psychiatric collaborative care management</td>
<td></td>
</tr>
<tr>
<td>99499</td>
<td>Unlisted evaluation and management service</td>
<td>Not reimbursable; submit with appropriate evaluation and management code</td>
</tr>
</tbody>
</table>
### Provider Payment Guidelines

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Short Descriptor</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4580, A4590; Q4001-Q4051</td>
<td>Casting supplies</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>G0425-G0427</td>
<td>Telehealth consultation, emergency department or initial inpatient, communicating with the patient via Telehealth.</td>
<td>Not reimbursable; submit with appropriate evaluation and management code</td>
</tr>
<tr>
<td>G2211</td>
<td>Add on code for complexity E&amp;M visit</td>
<td></td>
</tr>
<tr>
<td>G2212</td>
<td>Prolonged office or other outpatient E&amp;M service(s)</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive Visit and Problem Visit Same Day

<table>
<thead>
<tr>
<th>Category</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Medicine and Problem-Focused E/M Services</td>
<td>Reimbursement is made for two different E/M services on the same day, only when a provider submits a problem-focused office visit procedure code with a preventive medicine procedure code and the appropriate modifier is appended to the problem-focused code. Reimbursement for the higher valued service will be made at 100% of the contracted allowable rate, and reimbursement for the lower valued service will be made at 50% of the contracted allowable rate.</td>
</tr>
<tr>
<td>Multiple Problem-Focused E/M Services</td>
<td>Reimbursement is made for more than one E/M procedure code for a single date of service when such services are rendered by providers, including mid-level practitioners, of different specialties. Only one E/M service is allowed for a single date of service for the same provider group (same TIN) and same specialty, regardless of place of service. Exception: Obstetrical care - Clinicians in the same practice, or back-up physicians, coverage providers including physicians, nurse midwives, physician assistants, or nurse practitioners that are owners, partners, employees, or contracted staff at the practice may provide components of the care but are not separately reimbursed.</td>
</tr>
<tr>
<td>Category</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E/M Services within a Global Period</td>
<td>• Reimbursement is made for E/M services rendered during the global period when the service is distinct and unrelated to the primary procedure and supported by the documentation.</td>
</tr>
<tr>
<td>Critical Care Services</td>
<td>• Reimbursement is not made for any E/M service when billed with a critical care service</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>• Reimbursement is made for certain E/M services when performed via telemedicine. Refer to the <a href="#">Telemedicine Payment Policy</a> for more information.</td>
</tr>
</tbody>
</table>

**Related Documents**

- [General Coding and Billing](#)
- [Modifiers](#)
- [Newborn Care Payment Policy](#)
- [Observation Services Payment Policy](#)
- [Preventive Services Payment Policy](#)
- [Telemedicine Payment Policy](#)

**References**

- 1995 CMS Documentation Guidelines for Evaluation and Management Services
- 1997 CMS Documentation Guidelines for Evaluation and Management Services
- [AMA CPT Evaluation and Management Changes Effective 01/01/2023](#)
- [CMS Evaluation and Management Services Guide, MLN006764, January 2022](#)
- [CMS Global Surgery Booklet](#)
- Current year CPT, Professional Edition published by the AMA (American Medical Association)
- [MassHealth Physician Manual](#)
- [MassHealth Transmittal Letter AOH-56, September 2023](#)

**Publication History**

<table>
<thead>
<tr>
<th>Topic: Evaluation and Management</th>
<th>Owner: Network Management</th>
</tr>
</thead>
</table>

- *April 12, 2010* Original documentation
- *April 19, 2011* Updated authorization grid, smoking cessation, new 2011 CPT code, references
Provider Payment Guidelines

July 8, 2011  Corrected observation code numbers updated “Mass General Brigham Health Plan Does Not Reimburse”, updated code grid to include: 99354-99359, and updated 99058 to require documentation

August 29, 2011  Corrected range 99221-99223, 99231-99239, 99147-99150, added procedure code grid, non-coverage of consult codes, and references changed.

August 1, 2013  Policy name change, authorization grid, and added HCPCS G0436 for GIC tobacco cessation services, CPT 99024 added to grid as not reimbursed, CPT 99051 and 99058 updated to not reimbursed

February 1, 2014  Policy updated to reflect NCCI Mod 25 E/M rules effective Jan 1, 2013, expanded code list of telehealth services

February 1, 2017  Document restructure, code review and changes, complexity and separation to the categories of E/M, telehealth codes 99441-99443 added, inpatient E/M codes were corrected, removed definition, removed/added references, added related Mass General Brigham Health Plan payment guidelines, added hyperlinks

July 15, 2017  Code review; change to telemedicine reimbursement information; addition to Related Documents links

January 01, 2019  Document restructure; codes, code descriptor and references updated

April 17, 2020  Added G0245-G0427, Language was added (Reimbursable for the duration of the Covid-19 State of Emergency)

January 05, 2021  Added 99417, G2211-G2212, Updated Policy language, link to 2021 E&M Guidelines

January 01, 2023  Document rebrand; updated codes references

September 01, 2023  Added MassHealth Transmittal Letter AOH-56 guidance
This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Mass General Brigham Health Plan utilizes clinical coding criteria and claim editing logic in addition to auditing across dates of service to identify the unbundling of pre- and post-operative care.