Evaluation and Management Services

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Important Note About This Policy

Oscar's reimbursement policies serve as a guide to assist providers with accurate claims submission and outline the basis for reimbursement if the service is a covered benefit. Coverage does not guarantee reimbursement; services must meet authorization and medical necessity guidelines for the procedure, diagnosis, and member's state of residence.

Our policies provide general reference for described services and do not cover every aspect of reimbursement. Other factors may supplement, modify, or supersede this policy, including legislative mandates, provider contracts, member benefit documents, and/or other reimbursement, medical, or drug policies. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

Providers are responsible for submission of accurate documentation of services performed. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Oscar routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later. Oscar communicates policy updates to providers via update notifications.

Description

Evaluation and Management (E/M) codes represent the services performed by physicians and other qualified healthcare professionals to evaluate and manage a member's health. E/M services are reported according to the applicable category and level of service based on factors including patient type, place and setting of service, medical decision making (MDM), time, and other requirements applicable to the reported service. E/M services may be provided in a variety of settings, including office and other outpatient settings, inpatient and observation settings, emergency departments, nursing facilities, and home or residence settings. Requirements for reporting an E/M service vary by code family and setting. E/M services must adhere to the criteria outlined in the current version of the CPT® manual.

Policy

Oscar incorporates standards established by the Centers for Medicare and Medicaid Services (CMS), and the American Medical Association (AMA) for this policy. All services should be coded to the appropriate level of care, as laid out in the CMS, and AMA guidelines. All E/M leveling should be able to be substantiated by medical records. Additionally, Oscar may consider some services integral or included in the E/M service. These services are not separately reimbursable.

For the purpose of this policy, same group practice is defined as a physician and/or other qualified health care professional of the same group and same specialty with the same Federal Tax ID number.

Reimbursement Guidelines

E/M services must be reported using the code that accurately represents the patient type, setting, encounter, and level of service performed. Documentation must support the necessity and requirements of the reported service.

Services that are integral to an E/M service, included in the selection of the E/M level, or otherwise considered included under applicable coding or Oscar reimbursement guidelines are not separately reimbursable unless applicable requirements for separate reporting are met

New and Established Patients

Oscar follows the AMA CPT® codebook definitions of new and established patients for evaluation and management service codes.

- **New Patient** - A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
- **Established Patient** - An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

E/M codes meeting these definitions will either have “new” or “established” within the code description. Claims billed with a new patient evaluation and management code will be denied if there is another new or established patient claim on file within the previous three years from the same physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice.

Initial and Subsequent Services

Oscar follows the AMA CPT® codebook definitions of initial and subsequent for evaluation and management service codes.

- **Initial Service** - An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay.
- **Subsequent Service** - A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

E/M codes meeting these definitions will either have “initial” or “subsequent” within the code description. Claims billed with an initial service evaluation and management code will be denied if there is another initial service claim on file for the stay.

E/M Level Selection

Oscar follows the E/M guidelines outlined in the current edition of the AMA CPT® codebook. Providers must report E/M services in accordance with the requirements applicable to the reported code and code family.

When permitted by the applicable code set, the level of an E/M service may be selected based on either medical decision making (MDM) or total time on the date of the encounter. A medically appropriate history and/or physical examination should be performed and documented when clinically indicated; however, the extent of the history and physical examination does not determine the level of the E/M service.

Documentation must support the level of service reported and the applicable requirements for MDM or time. The amount or volume of documentation alone does not determine the level of E/M service eligible for reimbursement. Providers should refer to the current AMA CPT® codebook for the requirements applicable to MDM and time.

- **MDM** - The level of MDM for an E/M service is determined based on three core elements: the number and complexity of problems addressed; the amount and/or complexity of data reviewed and analyzed; and the risk of complications and/or morbidity or mortality. The AMA publishes a MDM table to help determine the appropriate level of MDM for an encounter.

- **Time** - When time is used to select the level of service, documentation must support the total time and applicable activities used to determine the reported service. Time associated with another separately reported service may not also be counted toward selection of the E/M level.

Prolonged Services

Prolonged E/M services may be separately reimbursable when reported with an eligible primary E/M service and all applicable CPT®, HCPCS, CMS, time, documentation, and Oscar reimbursement requirements are met. When time is used to report a prolonged E/M service, documentation must support the total time associated with the primary E/M and prolonged service in accordance with applicable coding requirements. Time associated with another separately reported service may not also be counted toward the primary or prolonged E/M service.

Reimbursement for prolonged E/M services are subject to the following:

- Prolonged office or other outpatient E/M add-on services, including 99417 and G2212, as applicable, may be separately reimbursable when reported with an eligible primary E/M service and applicable time requirements are met.
- Prolonged services without direct patient contact (99358 and 99359) are not separately reportable from a face-to-face E/M on the same date per CPT coding instructions, therefore is not separately reimbursable.
- Prolonged services reported without an eligible primary service, when required, or that do not satisfy applicable time, documentation, or other reporting requirements are not separately reimbursable.
- Prolonged services reported with comprehensive preventive medicine services are subject to Oscar's Preventive Medicine Services reimbursement policy.

Modifiers

Code modifiers used for E/M services billing should be appropriate for the services rendered and should be able to be supported by medical records. Oscar may verify modifier appendage by requesting medical records, review of diagnosis, and claim history to ensure that included modifiers adhere to the standards outlined by the CMS, and AMA (ex. 25, FS). Please see Oscar’s Modifier Guidelines reimbursement policy for additional details on modifier reporting rules and information.

Multiple E/M Services on the Same Date

Oscar will reimburse one E/M service visit per billing group, per subspecialty, per day. There are times where a member will be seen by a provider or group practice more than once per day for E/M services. A single code should typically be reported for all related E/M services a member is provided each day. Physicians and/or other qualified health care providers in the same group practice should select the appropriate code level representative of the cumulative related services.

If both preventive and problem-oriented services are billed on the same day, and the problem-oriented visit is billed with modifier 25, Oscar will reimburse the higher-valued procedure at 100% of the otherwise allowable amount and the lower-valued procedure at 50% of the contracted rate. Problem-oriented visits billed without modifier 25 in conjunction with a preventive visit will not be reimbursed. Please see Oscar’s Preventive Medicine Evaluation and Management Services policy for additional information.

Other E/M Services will be paid at 100% when billed with modifier 25, unless addressed elsewhere within this policy.

E/M During Global Surgical Periods

E/M services are not separately payable when provided on the same day (or the day prior, for major surgical procedures) as a procedure with a global period, as defined by the CMS or Oscar (for codes with global surgery indicator YYY). Exceptions to this policy are for significant and separately identifiable services, when billed with modifier 25, or for services resulting in a decision to perform a major surgery, when billed with modifier 57. For services billed with modifier 25, the lesser of the procedure (CPT range 10000 - 69999) or E/M rate is paid at 50% of the contracted rate. Oscar may verify whether services are related or truly separate and significant. Review criteria includes, but is not limited to, diagnoses, claim history, and medical records.

Additionally, E/M services provided within the global period are not considered separately payable unless unrelated to the original procedure and billed with modifier 24.

E/M and Other Services on the Same Date

In alignment with CMS National Correct Coding Initiative (NCCI) and other industry guidance, Oscar considers some E/M services integral to the completion of certain services and tests when performed on the same date of service. These may not fall into the categories of services with global periods as described above. In these scenarios, separate reimbursement will not be allowed unless modifier 25 guidelines are followed.

Examples include, but are not limited to:

- E/M performed in the same location as critical care services (99291-99292). Please see Oscar's Critical Care / Trauma Activation reimbursement policy for more details on these services.
- E/M performed in conjunction with cardiovascular services
- E/M performed in conjunction with electromyographic (EMG) test, nerve conduction study (NCS), blink reflex test, or neuromuscular junction (NMJ) testing

Split / Shared Services

Split or shared services should be reported using modifier FS on the professional claim for an eligible split/shared E/M service furnished in a facility setting. This indicates that although the claim is submitted under a single provider's NPI, more than one provider performed the visit. Payment will be made to the practitioner who performs the substantive portion of the visit. The CPT® codebook states that if the code selection is based on total time, the substantive portion would be the provider who spent the majority of the face-to-face time performing the service. With services based on MDM, the substantive portion would be the provider who performed two of the three elements used in the selection of the code level and who made or approved the management plan and takes responsibility for the risk of complications and/or morbidity or mortality of patient management.

Consultation Services

In accordance with CMS, Oscar will no longer separately reimburse for office/outpatient consultation codes (CPT® codes 99242–99245) and inpatient/observation consultation codes (CPT® codes 99252–99255). Consultation services should be reported with an appropriate office/outpatient or inpatient/observation E/M code representing the location where the visit occurred and the level of complexity of the visit performed, such as code ranges 99221-99223, 99304-99306, and 99202-99215.

Interprofessional Consultation Services

Interprofessional telephone/internet consultation services are provided by a consulting physician at the request of the patient's primary or treating physician to assist in the diagnosis and/or management of the patient's problem without a face-to-face encounter with the consultant. 99446, 99447, 99448, 99449, 99451, 99452 are considered incidental and not eligible for separate reimbursement.

Standby and On-Call Services

Standby and hospital mandated on-call services represent services where the attendance of the provider is requested but do not involve direct, face-to-face patient contact. Therefore, Oscar considers standby services (99360), hospital mandated on call service; in hospital, each hour (99026), and hospital mandated on call service; out of hospital, each hour (99027) incidental to E/M services and not separately payable.

Hospital Discharge Day

Only one hospital discharge day management service (CPT® 99238-99239) will be reimbursed per patient per hospital stay according to CMS policy. Additionally, only the attending physician is to report the discharge day management service. Subsequent hospital discharge day management services will not be eligible for reimbursement for the same date of service.

Included and Non-Separately Reimbursable Services

Certain services performed in conjunction with an E/M service are considered integral, incidental, or otherwise included in the reimbursement for the E/M service and are not separately reimbursable unless the requirements for separate reporting are met.

Services that may be included in or not separately reimbursable with an E/M service include, but are not limited to:

- Removal of impacted earwax (69209 and 69210)
- Peak expiratory flow rate (S8110)

Other services may be considered included in an E/M service under applicable CPT®, CMS, NCCI, or Oscar reimbursement guidelines.

Appending modifier 25, modifier 59, an X{EPSU} modifier, or another modifier does not independently establish eligibility for separate reimbursement when the underlying service is considered inclusive or integral to the E/M service or does not otherwise meet applicable requirements for separate reporting.

Related Policies

Bundled Services

Modifier Guidelines
Preventive Medicine Services
Telehealth and Telemedicine Services

References

1. American Medical Association, CPT®, Evaluation and Management Services Guidelines
2. Centers for Medicare and Medicaid Services IMedicare Benefit Policy Manual, Pub. 100-02, Chapter 15
3. Centers for Medicare and Medicaid Services Medicare Claims Processing Manual, Pub. 100-04, Chapter 12
4. Centers for Medicare and Medicaid Services, National Correct Coding Initiative Policy Manual, Chapter I
5. Centers for Medicare and Medicaid Services, National Correct Coding InitiativePolicy Manual, Chapter XI
6. Centers for Medicare and Medicaid Services, National Correct Coding Initiative Policy Manual, Chapter XII

Publication History

Date	Action/Description
4/02/2017	Original Documentation
4/20/2017	Approval and inclusion in Oscar Provider Manual
7/20/2017	Policy Updated
8/29/2018	Policy Updated
4/09/2019	Policy Updated
3/26/2020	Policy Updated
6/10/2020	Policy Updated
06/25/2024	Annual Review; Description section added; Added New Patient Frequency Parameters, Added Annual Wellness limits based on definition, Deleted Statement about Cardiovascular Stress Test, Added FS modifier requirement for split/shared visits, Deleted Statement that I&R of CXI being bundled into ED visit, Added Standby Services as bundled, Added Peak Expiratory Services as bundled, Added statement that cardiovascular services bundled in E&M unless modifier appended, Added Initial and Subsequent chronological filing requirement, Updated Consult codes as no longer payable, but to be resubmitted with appropriate E&M code, Adde Interprofessional telephone/internet consult statement, Rephrased Care Management Code verbiage to align with updated coding, Added Critical Care services coding requirements, Added Hospital Mandated on Call services, Added Hospital Discharge Day information, Added EMG test statement, Updated coding section to align with updated codes.

03/27/2025	Off-cycle verbiage update to Screening/Counseling/Nutrition Therapy/Prolonged Services/Overlapping E&M Services section of policy.
01/12/2026	Off-cycle update to remove Emergency Department (ED) Facility E&M Coding section and associated FAQ information as a new self-titled policy was created for this topic.
10/12/2026	Annual Review. Added standard disclaimer statement; Updated Description section; Updated Policy Section; Added introductory statement to Reimbursement Guidelines section; Added New and Established Patients subsection with definitions and frequency parameters; Relocated Initial and Subsequent Services subsection to higher within policy and added definitions; Added E/M Level Selection subsection; Relocated Prolonged Services into its own subsection, moved it up within the policy, and added more information on the subject; Renamed Multiple Visits Per Day subsection to Multiple E/M Services on the same date and relocated information from the Description section into this subsection; Relocated E/M During Global Surgical Periods within the policy to optimize flow; Added E/M and Other Services on the Same Date subsection to encompass items already within the policy such as critical care, cardiovascular services, and EMG, NCS, and NMJ testing; Moved Split or Shared E&M Visits subsection to later in the policy and updated the title of the subsection to Split / Shared Services; Relocated Screening, Counseling, Nutrition Therapy into new Preventive Medicine Services reimbursement policy; Relocated information from Bundled Services to elsewhere in the policy or to Preventive Medicine Services policy; Renamed Consultation Codes subsection to Consultation Services; Split out Interprofessional Consultation Services into its own subsection; Relocated Care Management Services information to Bundled Services reimbursement policy; Relocated Critical Care information into E/M and Other Services on the Same Date subsection and reduced the information as it is covered within the Critical Care / Trauma Activation reimbursement policy; Renamed Hospital Mandated On Call Service subsection to Standby and On-Call Services and relocated standby service stance to this subsection from the now removed Bundled Services subsection; Deleted Electromyographic (EMG) test, nerve conduction study (NCS) subsection and relocated the information into E/M and Other Services on the Same Date subsection; Added Included and Non-Separately Reimbursable Services subsection and relocated some topics from the now removed Bundled Services subsection to here; Removed Billing and Coding section as applicable codes are now located within the policy for ease of reference; Updated Related Policies section to include additional policies and put the policies in alphabetical order; Added additional items to the References section; Changed E&M to E/M throughout the entire policy to align with the AMA CPT codebook.