

<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 1 of 14</b>

**1. POLICY DESCRIPTION: Evaluation and Management (E/M) Reimbursement Policy, Professional**

This policy pertains to the selection of appropriate CPT E/M codes. Health plan reimbursement is based on the health care services provided. The code(s) reported by physicians or other qualified health care professionals should best represent the services provided based on the AMA and CMS documentation guidelines. Refer to the References section below for further guidance on documenting and reporting E/M services accurately.

Effective January 1, 2023, The AMA released revised E/M guidelines. With the exception of CPT codes 99281-99285, providers may choose the appropriate E/M level using either Medical Decision Making (MDM) *or* time as the basis for selecting a code level.

The AMA CPT Editorial Panel approved the above revisions to the following E/M CPT codes:  
 Office or other Outpatient visits (CPT codes 99202-99205, 99211-99215)  
 Hospital Inpatient and Observation Care visits (CPT codes 99221-99223, 99231-99239)  
 Consultation visits (CPT codes 99242-99245, 99252-99255)  
 Emergency Department visits (CPT codes 99281-99285)  
 Nursing Facility visits (CPT codes 99304-99310, 99315, 99316)  
 Home or Residence visits (CPT codes 99341, 99342, 99344, 99345, 99347-99350)  
 Prolonged visits (CPT codes 99358, 99359, 99415-99418)

Code descriptors and documentation standards were updated to directly address the continuing problem of administrative burden for physicians in nearly every specialty across the country.

**2. RESPONSIBLE PARTIES:**

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting, Special Investigation Unit, Compliance.

**3. DEFINITIONS:**

**Encounter** - Interaction between a covered member and a health care provider for which evaluation and management service or other service(s) are rendered and results in a claim submission.

<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 2 of 14</b>

#### 4. POLICY:

MetroPlus utilizes Lyric’s ClaimxXten software as part of its claims editing process to ensure proper reimbursement of claims. ClaimsXten compares submitted claims to standard American Medical Association (AMA) CPT® coding and CMS-approved NCCI (National Correct Coding Initiatives) guidelines. If the submitted coding does not meet current CPT/NCCI standards, the software provides the most appropriate coding. ClaimsXten is designed to detect coding discrepancies automatically.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

MetroPlus Health Plan may request medical records when tracking data shows a physician or other qualified health care professional has a billing pattern that deviates significantly from their peers.

The medical record review process takes into consideration CMS and AMA documentation guidelines.

##### **Time-Based level of Service:**

Documentation criteria for time spent face-to-face or non-face-to-face may include, but not limited to:

- Assessing and examining the patient
- Providing counseling and health education
- Reviewing medical history and diagnostic results
- Documenting and interpreting clinical findings
- Coordinating care and making referrals
- Communicating with other healthcare providers
- Ordering diagnostic testing, procedures, or medications

Time should NOT include:

- Time spent by support or clinical staff

<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 3 of 14</b>

- Time the patient waits to see the provider
- Time spent on separately reported services performed on the same day

The total time spent should be documented in the chart that supports the level of service that was billed. The documentation should also include activities that support the total time spent.

**MDM-based (Medical Decision Making) Level of Service:**

When leveling is based on MDM, the following components are used and 2 out of 3 elements must be met or exceeded for the overall MDM:

- Number/Complexity of Problems Addressed at the Encounter
- Risk of complications and/or morbidity or mortality of patient management
- Amount and/or Complexity of Data to be Reviewed and Analyzed
  - Orders or interpretation of tests, images and data cannot be included toward the MDM level if these are billed separately

MDM levels are:

- Straightforward
- Low
- Moderate
- High

Providers may experience adjustments to, or denials of the E/M code reported if the documentation does not support the E/M level submitted. The provider may resubmit the claim with a revised E/M code for denied claims.

**5. LIMITATIONS/ EXCLUSIONS:**

Important Note:

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve as a general reference resource regarding MetroPlus Health Plan’s reimbursement policy for the services described and is not intended to



<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 4 of 14</b>

address every aspect of a reimbursement situation. Accordingly, MetroPlus Health Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to MetroPlus Health Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee’s benefit coverage documents, and/or other reimbursement, medical or drug policies.

Providers are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that physicians and other qualified health care professionals are reimbursed based on the code or codes that correctly describe the health care services provided. MetroPlus Health Plan reimbursement policies use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS) and/or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by MetroPlus Health Plan due to programming or other constraints; however, MetroPlus Health Plan strives to minimize these variations.

MetroPlus Health Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

(CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.)

**6. APPLICABLE PROCEDURE CODES:**

CPT	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 5 of 14</b>

<b>99203</b>	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
<b>99204</b>	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
<b>99205</b>	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
<b>99211</b>	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
<b>99212</b>	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
<b>99213</b>	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
<b>99214</b>	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
<b>99215</b>	Office or other outpatient visit for the evaluation and management of an established patient, which a medically appropriate history and/or examination and high level of medical decision making.



<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management</b>
<b>Approval Date: 3/15/19</b>	<b>Department: Utilization Management</b>
<b>Effective Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Review Date: 6/16/2026</b>	<b>Policy Number: UM-MP245</b>
<b>Retired Date:</b>	<b>Cross Reference Number:</b>
	<b>Page 6 of 14</b>

When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

<b>99221</b>	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
<b>99222</b>	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
<b>99223</b>	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
<b>99231</b>	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
<b>99232</b>	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
<b>99233</b>	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
<b>99234</b>	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
<b>99235</b>	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.



<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 7 of 14</b>

99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
99239	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99252	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99253	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99254	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
99255	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional



<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 8 of 14</b>

99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
99288	Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to primary CPT code 99291)
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.



<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 9 of 14</b>

<b>99309</b>	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
<b>99310</b>	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
<b>99315</b>	Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
<b>99316</b>	Nursing facility discharge management; more than 30 minutes total time on the date of the encounter
<b>99341</b>	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
<b>99342</b>	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
<b>99344</b>	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
<b>99345</b>	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
<b>99347</b>	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
<b>99348</b>	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 10 of 14</b>

<b>99349</b>	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
<b>99350</b>	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.



**7. APPLICABLE DIAGNOSIS CODES:**

CODE	Description


**8. REFERENCES:**

For Evaluation and Management Services documentation it is recommended that providers refer to the following publications.

- 1) This table provides evaluation and management (E/M) services resource information.

FOR MORE INFORMATION ABOUT...	RESOURCE
Evaluation and Management Services	<a href="#">Medicare Benefit Policy Manual</a> (Publication 100-02) and the <a href="#">Medicare Claims Processing Manual</a> (Publication 100-04)  <a href="#">AMA 2021 Evaluation and Management Updates</a>  <a href="#">AMA 2023 Evaluation and Management Updates</a>  <a href="#">CMS Evaluation and Management Visits</a>
HCPCS	<a href="https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo">https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo</a>
ICD-10-CM/PCS	<a href="https://www.cms.gov/Medicare/Coding/ICD10">CMS.gov/Medicare/Coding/ICD10</a>

<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 11 of 14</b>

CPT® Books	American Medical Association (AMA) <a href="https://commerce.ama-assn.org/store">https://commerce.ama-assn.org/store</a>
All Available Medicare Learning Network® (MLN) Products	<a href="#">The Medical Learning Network</a>
Provider-Specific Medicare Information	<a href="https://learner.mlnlms.com/">https://learner.mlnlms.com/</a>
Medicare Information for Patients	<a href="#">Medicare.gov</a>
Medicare Benefit Policy Manual	<a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html">https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html</a>
Medicare Claims Processing Manual	<a href="https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html">https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html</a>
	
AMA 2021 Evaluation and Management Updates	<a href="https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf">https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf</a>
AMA 2023 Evaluation and Management Updates	<a href="https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf">https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf</a>
MLN Catalog	<a href="https://www.cms.gov/training-education/medicare-learning-network/resources-training">https://www.cms.gov/training-education/medicare-learning-network/resources-training</a>
	

- 2) Individual state Medicaid regulations, manuals & fee schedules
- 3) Medicare Claims Processing Manual (Pub. 100-4), available at [www.cms.hhs.gov/Manuals/](http://www.cms.hhs.gov/Manuals/) on the CMS website; and
- 4) *Current Procedural Terminology* book, available from the American Medical

<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 12 of 14</b>

Association (800-621-8335 or [www.amapress.org](http://www.amapress.org) on the Web).

- 5) American Medical Association, Current Procedural Terminology ( CPT® ) Professional Edition and associated publications and services
- 6) Medicare Learning Network Bulletin Evaluation and Management Services MLN006764 March 2026. <https://www.cms.gov/files/document/mln006764-evaluation-management-services.pdf>  
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>
- 7) Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services including but not limited to 2021 and 2023 guidelines.  
[2021 Guidelines: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf](https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf)  
[2023 Guidelines: https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf](https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf)
- 8) Evaluation and Management Documentation Training Tool

**REVISION LOG:**

<b>REVISIONS</b>	<b>DATE</b>
Creation date	1/30/2019
Annual Review	6/8/2020
Revised due to CPT Code changes	3/30/2021
Annual Review	4/26/2022
Annual Review	5/27/2025
Annual Review	6/16/2026



Policy and  
Procedure

<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 13 of 14</b>

**Approved:**

---

**Dr. Sanjiv Shah  
Chief Medical Officer**



<b>Title: Evaluation and Management (E/M) Reimbursement Policy, Professional</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 3/15/19</b>	<b>LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 3/15/19</b>	<b>Policy Number: UM-MP245</b>
<b>Review Date: 6/16/2026</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 14 of 14</b>

**Medical Guideline Disclaimer:**

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member’s benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.