PROVIDER REIMBURSEMENT GUIDANCE Evaluation & Management Services		
Original Date Approved	**Effective Date**	**Revision Date**
12/07/2022	07/01/2026	04/21/2026

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (FIDE-SNP)

☒ One Care (FIDE-SNP)

PAYMENT POLICY SUMMARY

This policy provides guidance to providers on billing Evaluation and Management (E&M) services for members enrolled in Commonwealth Care Alliance (CCA) programs including Senior Care Options (SCO) and One Care. The policy aligns with CMS Medicare rules, MassHealth requirements, and CPT coding standards.

DEFINITIONS

Medical Necessity

Medical necessity is the overarching criterion for reimbursement of E&M services. Services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a body system. Documentation must support the presenting problem, clinical evaluation, medical decision making, and treatment plan. The volume of documentation alone does not determine the level of service billed.

History

The patient-related information gathered during the encounter, including the Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS), and Past, Family, and Social History (PFSH).

Examination

The physical assessment performed by the provider on the patient, which can range from a problem-focused exam to a comprehensive exam depending on the service level.

Medical Decision Making (MDM)

The complexity of establishing a diagnosis and/or selecting management options documented for the encounter, considering the number and complexity of problems addressed, data reviewed, and the risk of complications or morbidity.

Critical Care Services (CC Services): CC services are E/M services for patients with critical illness(es) or injury causing vital organ system impairment, a substantial risk of imminent and life-threatening deterioration.

Time
The total face-to-face and non-face-to-face time spent by the provider on the date of the encounter, including counseling, coordination of care, reviewing records, and documentation.

Counseling
Educating or advising the patient or family about diagnosis, prognosis, risks and benefits of treatment, and other aspects of care, which can be a key component in time-based billing.

Coordination of Care
Efforts made to manage and organize patient care across multiple providers or settings, including communication with other healthcare professionals.

Chief Complaint (CC)
The primary reason or symptom reported by the patient for seeking care.

History of Present Illness (HPI)
A detailed description of the patient's current health concern or complaint.

Review of Systems (ROS)
An inventory of body systems obtained through questions to identify symptoms the patient may be experiencing.

Past, Family, and Social History (PFSH)
Documentation of the patient's past health issues, family medical history, and social factors influencing health.

New Patient
A patient who has not received any professional services from the physician or qualified healthcare provider or another physician of the exact same specialty and subspecialty in the same group practice within the past three years.

Established Patient
A patient who has received professional services from the physician or qualified healthcare provider or another physician of the same specialty and subspecialty in the same group practice within the past three years.

Current Procedural Terminology (CPT) Codes
Standardized numeric codes used to describe medical, surgical, and diagnostic services for billing purposes.

Documentation
The recorded details of the patient encounter supporting the level of service billed, including history, exam, MDM, time, and counseling as applicable.

REIMBURSEMENT SUMMARY:

CCA will reimburse for medically necessary **Evaluation and Management (E&M) services** provided to Senior Care Options and One Care members.

Categories and subcategories of E & M encounter codes describe the range of service classifications. Key components appear in the descriptors for each code category with descriptions of the increasing levels of complexity.

The code(s) reported by each provider should best represent the services provided based on the American Medical Association (AMA) and CMS documentation guidelines.

CCA will reimburse Office or Outpatient E&M encounters based on the current criteria in force (i.e., AMA, CMS, E & M Guidelines, 2023). An appropriately updated and pertinent *History and Physical Examination* shall support the medical necessity of the services rendered but will not determine the codes selected (i.e., level of service LOS). E&M levels of service (LOS), other than critical care services, are determined by Medical Decision Making (MDM) or total time spent on the date of the encounter. MDM is based on three elements: problems addressed, data reviewed and analyzed, and risk of complications or morbidity related to patient management.

CCA may request medical records to ensure the appropriate level of E&M service is documented and reimbursed based on the complexity of the encounter.

REIMBURSEMENT REQUIREMENTS:

New Patient Offices visits will only be reimbursed the first time a patient sees a provider for professional services, and if the provider or another physician of the same specialty and same group practice of has not seen the patient for professional services within the last three years. (99201-99205).

Established Patient Office visits should be reported for those patients who have received professional services from the provider within the last three years. (99211-99215).

E&M services submitted with a Medicare Annual Wellness Visit: Problem focused E&M services can be billed with modifier 25 appended, when a significant abnormality or pre-existing condition is addressed, and additional work is required beyond the scope of the AWV to perform the key components of a problem focused visit.

E&M services provided with removal of impacted cerumen: CCA does not reimburse for removal of impacted cerumen when submitted on the same day as E&M services.

E&M services provided with an office/outpatient procedure: CCA does not allow for the separate reimbursement of E&M services when a substantial diagnostic or therapeutic procedure is performed. The usual care of the patient is already covered by the procedure.

E&M Services provided with lab collection and screening services: CCA will not reimburse G0102, Q0091, when billed on the same day as a preventive medicine service or problem-oriented service (99385-99387), (99395- 99397), (S0610, S0612), (99201-99205), and (99211-99215) regardless of the place of service. CCA will not separately reimburse 36415 and/or 36416 when billed with an office E&M visit, preventive medicine service, or office-based lab CPT codes (i.e., CLIA waived tests). (CCA will reimburse 36415 and 36416 when it is the sole service provided). CCA will not reimburse separately for 99000/99001 when billed with an E&M office visit or preventive medicine service. CCA will reimburse only non-OB/GYN PCP's for G0101 Breast & Pelvic Exam when billed on the same date of service as an E&M service regardless of location.

Multiple E&M Services: When multiple providers within the same specialty using the same federal tax identification number perform E&M services on the same patient, on the same day, only one E&M service will be reimbursed of the highest allowable amount.

Telephone E&M Services:

CCA reimburses telehealth services when the service is a covered Medicare and/or MassHealth benefit, medically necessary, and clinically appropriate for telehealth delivery. Telehealth services must comply with applicable CMS, MassHealth, and Federal regulatory requirements, and must be provided using HIPAA-compliant telecommunications technology.

Telehealth may be delivered through real-time audio-video communication or audio-only communication when permitted under Medicare or MassHealth policy. Providers must determine that telehealth is clinically appropriate and must document the modality used, the clinical reason telehealth was appropriate, and all required elements supporting medical necessity and the service provided.

Providers must bill telehealth services using the appropriate CPT or HCPCS code, place of service, and required modifiers, including POS 02 or POS 10, and Modifier 95 or Modifier 93 when applicable. Documentation and clinical standards for telehealth services must meet the same requirements applicable to equivalent in-person services.

For One Care and SCO members, telehealth coverage reflects the integrated Medicare–MassHealth benefit structure and may not be more restrictive than the governing coverage standards of either program. Telehealth services must meet applicable Medicare coverage requirements and MassHealth program rules.

Emergency Department Care: This entails E&M services that are rendered at a hospital for unscheduled episodic care to patients who present for immediate medical attention (the facility must be open 24 hours). Time is not a descriptive component for emergency department E&M levels of service and providers must use CPT codes 99281-99285 for emergency department visits (Place of Service 23) for both established patients and new patients for the emergency department visit. (Note: Providers or other healthcare professionals who are requested to serve as a consult should utilize the appropriate E&M code administered). Providers may experience adjustments to or denials of the office visit or other outpatient E&M code or emergency department E&M code reported if the documentation does not support the E&M level submitted.

Critical Care: In accordance with, but not limited to, the CPT definition of a critical care patient and inclusive of the CPT definition of critical care services – consistent with the total duration of time the physician spends providing his/her full attention to a critically ill or injured patient and the work directly related to the patients care.

- Patients must have a life-threatening condition involving failure or risk of failure of vital organ systems.
- Provider must perform high-complexity medical decision making to manage vital system function.
- Services must include the provider's direct, personal time.
- Total critical care time must be clearly documented.
- Time for separately billable procedures cannot be counted as critical care time.

Transitional Care Management:

CCA reimburses TCM services which support patients transitioning from an in-patient or institutional setting to the community. The following summary reflects CMS and MassHealth billing requirements for CPT codes 99495 and 99496.

Key Requirements:

- ✓ Discharge from hospital, observation, SNF, or similar institutional setting.
- ✓ Medication reconciliation performed no later than the face-to-face visit.
- ✓ Care coordination and management during the full thirty-day service period.
- ✓ Only one practitioner may bill TCM during the service period.
- ✓ Documentation must support medical necessity and care coordination activities.

Requirement	CPT 99495	CPT 99496
TCM Service Period	30 days post-discharge	30 days post-discharge
Interactive Contact	Within two business days of discharge	Within two business days of discharge
Face-to-Face Visit	Within 14 days of discharge	Within 7 days of discharge
Medical Decision Making	Moderate complexity	High complexity
Billing Timing	Bill after completion of thirty-day TCM period	Bill after completion of thirty-day TCM period
Date of Service on Claim	Date of face-to-face visit	Date of face-to-face visit
Eligible Billing Provider	Physician or qualified health professional	Same

Nursing Facility Services: Nursing Home E&M visits inclusive of services related to the admission and other related services when provided by the same physician (ex: Emergency Room, Doctor's Office).

Physician Home Visit: CCA reimburses physician home visits. In-Office Services Rendered on Sundays and Holidays: CPT code 99050 will only be reimbursed when provided in addition to basic services on Sundays and the following holidays: New Year's Day, Presidents Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Thanksgiving Day, and Christmas Day.

Common modifiers used with E&M services include:

Modifier	Description
Modifier 25	Significant separately identifiable E&M service on the same day as a procedure.
Modifier 24	Unrelated E&M service during postoperative period.
Modifier 27	Multiple outpatient hospital E & M encounters on the same date
Modifier 57	Decision for surgery.
Modifier 95	Telehealth service using audio/video
Modifier 93	Audio-only telehealth service

CCA reimburses an E&M service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with CPT modifier "-24" and accompanied by documentation that supports that the service is not related to the post-operative care of the procedure.

Global Surgical Period: CCA does not separately reimburse E&M services when reported with:

- Major surgical procedures (90-day global surgical period
- Minor procedures (10-day global surgical period)

CCA does separately reimburse for New Patient E&M services (992021-99205) when reported with procedures with a 0-day post-operative period.

COVERED E&M SERVICE CATEGORIES
E&M services covered under SCO and One Care programs include office visits, hospital inpatient services, observation services, emergency department visits, skilled nursing facility services, home or residence services, critical care services, and transitional care management services. Services must meet Medicare and MassHealth coverage requirements.

The Elements of Medical Decision Making (MDM) include:

- Number and complexity of *problems*
- Amount and/or complexity of *data reviewed* and analyzed
- *Risk* of complication and/or morbidity or mortality of patient management

Level one established patient office visits do not have a time component. This visit type occurs in instances where a physician or other qualified health care professional is not present.

MDM levels are selected based on the following:

MDM Level	*Problems Addressed*	*Data Reviewed*	*Risk*
Straightforward	Minimal problem	Minimal data	Minimal risk
Low	Stable chronic illness	Limited data review	Low risk
Moderate	Exacerbation of illness	Moderate diagnostic review	Moderate risk
High	Severe illness	Extensive diagnostic review	High risk

BILLING AND CODING GUIDELINES:

E&M service codes are a distinct set of CPT codes that are divided into various categories and subcategories based upon where the patient is treated and what level of treatment is required. There are numerous components of E&M services, including but not limited to:

- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of the Presenting Problem
- Time

This is not an all-inclusive list

Documentation must support the level of E&M service billed. Voluminous documentation does not justify a higher level of service than what is warranted. Medical necessity is the overarching criterion for payment.

Time Based Billing requires selecting the E & M code level based on the total provider's time spent on the patient's care on the date of the encounter, when permitted by that CPT code set, with documentation of the time, medical necessity, and any payer specific requirements such as telehealth modifiers.

Time is not a descriptive component for the Emergency Department levels of E&M services as these are provided on a variable intensity basis.

Coverage is limited to those E&M services that physicians and qualified non-physician practitioners are legally authorized to perform in accordance with federal and state regulations. CCA recognizes CPT's definition of services that are inclusive of E&M services which include examinations, evaluations, treatments, conferences, with or concerning patients.

New Patient Code	***Time***	***Est. Patient Code***	***Time***
99202	15–29 min	**99212**	10–19 min
99203	30–44 min	**99213**	20–29 min
99204	45–59 min	**99214**	30–39 min
99205	60–74 min	**99215**	40–54 min

DISCLAIMER:
As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance. CCA reserves the right to amend this payment policy at its discretion, to be binding on Provider. ICD, CPT/HCPCS codes are updated as applicable and such updates shall be deemed automatically incorporated into this Policy; providers must adhere to the most recent ICD, CPT/HCPCS coding guidelines, as applicable.

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REFERENCES:

- MLN006764 - CMS - Evaluation and Management Services Overview Nov. 2025
  MLN006764 - Evaluation and Management Services
- Medicare Claims Processing Manual – Chapter 12: Physicians/Nonphysician Practitioners
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- CMS Fee Schedule and E&M Code Updates
  https://www.cms.gov/medicare/physician-fee-schedule/search
- CCA SCO and One Care Contracts – 2026
  Procurement for One Care Plans and Senior Care Options (SCO) Plans for 2026 | Mass.gov

American Medical Association (AMA) Current Procedural Terminology (CPT®)
Commonwealth Care Alliance
Medicare Benefit Policy Manual 100-04 Ch 15 30.6.6

Payment Policies:
Massachusetts
Provider Manuals:
Massachusetts
Prior Authorization Forms:
Massachusetts

POLICY TIMELINE DETAILS
1. Effective 1/01/2018
2. Revised format, E&M, Modifier 24, 25, 27, 57 usage guidelines 8/2019
3. Reviewed 2020 annual update, no changes 4 4. January 2021 E&M guidelines updated 5. Revised November 2021, added MAP
4. Revised 4/21/2026
5 Effective 7/1/2026