Massachusetts | Commercial

Commercial Reimbursement Policy

Subject: **Documentation and Reporting Guidelines for Evaluation and Management Services – Professional**	
Policy Number: **C-09007**	Policy Section: **Administration**
Last Approval Date: **09/11/2025**	Effective Date: **09/11/2025**

Policy

The health plan allows reimbursement for evaluation and management (E/M) services when properly billed as described in this policy, unless provider, state, or federal contracts and/or mandates indicate otherwise.

For office and other outpatient E/M services and for "other" E/M services (including inpatient and observation visits, emergency department visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment), the health plan follows CMS guidelines for documentation and determination of service level, except:

- for split/shared services and consultation services criteria
- where this or other reimbursement policy differs

Note: All documents are subject to the Documentation Standards for Episodes of Care policy.

I. Documentation Requirements for the Use of Time

As described by CMS, time alone may be used to select a code level for certain E/M services. When time is used for reporting E/M codes, documentation must:

- Provide an exact time of service, rather than an approximate range of time, that is supported in the medical record
- Support the medical appropriateness of the visit
  - The summary should not just be a list of allowed elements, but instead a description of individual activities performed for that specific encounter.
  - A description of activities performed during the stated time must be documented.

Note: if the documentation requirements are not met for the use of time in establishing the level of service, then the claim will be evaluated using Medical Decision-Making (MDM) criteria.

II. Medical Decision-Making (MDM)

For services billed using MDM, documentation should reflect the appropriateness of the billed service code, as described by the health plan below.

A. Documentation Requirements

MDM is based on the patient's clinical condition at the time of the specific visit. The patient's medical record must include the following:

- For each encounter, an assessment, clinical impression, and/or diagnosis must be documented. The assessment, clinical impression, and/or diagnosis may be explicitly stated or implied in the documented decisions regarding management plans and/or further evaluation.
- The presenting problems need to be addressed in the history, physical examination, and MDM components.
    - For a presenting problem **with** an established diagnosis, the record should reflect whether:
        - the problem (s) is improved, well controlled, resolving, or resolved; or
        - inadequately controlled, worsening, or failing to change as expected.
    - For a presenting problem **without** an established diagnosis:
        - the assessment or clinical impression may be stated in the form of a differential diagnosis or as a possible, probable, or "rule out" diagnosis.
- The initiation of/or change in treatment must be documented.
- If referrals are made, consultations requested, or advice sought, the record must indicate to whom or where the referral or consultation is made, or from whom advice is requested.
- If diagnostic services (tests or procedures) are ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service must be documented.
- The review of lab, radiology, and/or diagnostic tests must be documented. A simple notation is acceptable; or the review may be documented by the provider initialing and dating the report containing the test results.
- Relevant findings from the review of old records and/or receipt of additional history from the family, caretaker, or other source to supplement the information obtained from the patient must be documented. If there is no relevant information beyond that already obtained, that fact should be documented; a notation of "old records reviewed" or "additional history obtained from family" without elaboration is insufficient.

B. Selecting a Level of Medical Decision Making for Coding an E/M Service

The health plan uses the 2021 AMA CPT® Level of MDM Table to quantify the complexity of problems addressed, complexity of data to be reviewed and analyzed, and risk of complications and/or morbidity and mortality to determine the appropriate level of E/M service to select.

Related Coding	
Description	**Codes**
Office-and-Other-Outpatient and Other E/M Codes	Office-and-Other-Outpatient and Other E/M Codes

Definitions	
Medical Decision Making (MDM)	The complexity of establishing diagnoses, assessing the status of a condition, and/or selecting a management option; determined by: • The number and complexity of problem(s) that are addressed during the encounter.

	• The amount and/or complexity of data to be reviewed and analyzed. • The risk of complications and/or morbidity or mortality of patient management.
General Reimbursement Policy Definitions	

References and Research Materials

This policy has been developed through consideration of the following:
• Optum EncoderPro, 2025
  ○ Current Procedural Coding Expert: AMA CPT® Evaluation and Management (E/M) Services Guidelines
• Centers for Medicare and Medicaid Services (CMS)
  ○ CMS Final Rule, 2023 (87 FR 69404)
  ○ CMS Medicare Learning Network (MLN)
  ○ 1995 and 1997 Documentation Guidelines for E/M Services

Related Policies and Materials
Bundled Services and Supplies – Professional
Consultations – Professional
Documentation Standards for Episodes of Care – Professional and Facility
Prolonged Services – Professional
Virtual Visits – Professional and Facility

Policy History	
09/11/2025	Review approved and effective: updated Definitions and Related Policies and Materials sections
0614/2023	Review approved and effective: updated policy language to select a level of MDM based on the 2021 AMA CPT® Level of MDM Table; related code list updated to include “other” E/M services
02/08/2023	Review approved and effective: updated policy language to follow CMS guidelines (including changes detailed in the 2023 CMS Final Rule); added language specifying the documentation requirements when using time to determine service level; now allow “Other” E/M services to be determined using time
12/16/2020	Update approved 12/16/2020 and effective 01/01/2021: added language adopting 2021 AMA, CPT® code changes; moved section for relaxing CMS documentation requirements to include all E/M services; updated definition section
09/14/2020	Review approved: policy updated with minor administrative changes including language relaxing documentation requirements according to the CMS 2019 Final Rule
06/01/2019	Revised: policy template updated; removed coding section, description section and added definitions
07/13/2018	Review approved 07/13/2018 and effective 01/01/2019: policy language updated; language added to describe an established patient when a provider changes group practices
09/06/2016	Revision under section 3 regarding Medical Decision Making (MDM); we no longer require MDM to be one of the key components of an established

	E/M but expect the MDM align with the complexity of the history and physical examination (HPE).
10/06/2015	Review approved: policy language updated to clarify that our language is based on CPT® guidelines
10/07/2014	Review approved: policy language reformatted
12/03/2013	Review approved: policy language updated; minor updates to punctuation and wording; added the definition to define new vs. established patient
12/04/2012	Revised: added language regarding signature on medical records
09/13/2011	Revised: policy language updated to clarify that documentation of a physical exam is required for an est. visit only if that key component is chosen; policy language updated to clarify that the 2/3 key components are typically used, but time may be used for visit level
01/01/2011	Revised: policy language updated; three new 2011 observation codes (99224-99226), which require key components for determining an E/M level, were added to the coding section of this policy; the short coding for time statement was deleted and a new policy section IV Counseling and Coordination of Care was added
11/02/2010	Policy language updated; the short coding for time statement was deleted and a new policy section 'IV Counseling and Coordination of Care' was added
04/06/2010	Revised: policy language updated; coding section expanded to include all codes requiring 2-3 key components
08/04/2009	Initial approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup

and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Use of Reimbursement Policy
This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.