Payment Policy: Leveling of Care: Office-based Evaluation and Management Overcoding

Reference Number: CC.PP.066
Date of Last Revision: 03/2026

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Physician medical records should chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history. Documentation should support the medical necessity and appropriateness of the diagnosis and/or therapeutic service provided. General principles of evaluation and management services (E/M) documentation established by CMS dictate that providers report diagnosis and treatment codes on the claim form that are consistent with the documentation in the medical record.

There are two **key** components providers must consider when selecting the appropriate level of E/M services provided, Medical Decision Making (MDM) and time.

Providers should select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **OR**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting Level of Service Based on Medical Decision Making

- 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. These data include:
    - Medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately.
        - Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of

benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented.

- Data are divided into three categories:
  1. Tests, documents, orders, or independent medical histories. Each unique test, order, or document is counted to meet a threshold number.
  2. Independent interpretation of tests (not separately reported)
  3. Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported).

- The risk of complications and/or morbidity or mortality of patient management. This includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s), including the possible management options selected and those considered but not selected after shared decision making with the patient and/or family.
  - For example, a decision about hospitalization includes consideration of alternative levels of care, such as in the following scenarios: a psychiatric patient with a sufficient degree of support in the outpatient setting or a patient with advanced dementia and an acute condition that would generally warrant inpatient care, but for whom the goal is palliative.

Guidelines for Selecting Level of Service Based on Time

- Time for these services equates to the total time spent caring for the patient on the date of the encounter, as documented in the medical record. It includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified healthcare professionals on the date of the encounter in activities normally performed by clinical staff.
- Calculation of total time does not include any time spent performing other separately reported service(s).
- Only distinct time should be summed. When two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted.

The purpose of this policy is to ensure that the level of E/M service reported by the provider reflects the services performed. When a provider submits an E/M service that exceeds the maximum level of E/M service based on the diagnosis and other claim documentation elements, the E/M code is reduced to reflect the maximum level of E/M service.

Application

- Physicians and other qualified health care professionals who provide face-to-face services who report evaluation and management services reported by a specific CPT® code(s).
- New office visits, established office visits, new ophthalmology visits, established ophthalmology visits, consult office visits
- This policy **does not apply** to professional claims billed in the emergency room setting 99281-99285.

Reimbursement

The health plan will provide an automated pre-payment (after services are rendered, but prior to claims payment) ***claims*** review process for determining the correct level of E/M service and adjusting payment to match the assigned E/M level, if different than what was billed on the claim.

The coding algorithm will evaluate each diagnosis code billed in the claim header, along with historical claims and other claims information (including additional testing/procedures) and determine if the level of E/M service billed is appropriate for the services rendered.

When multiple diagnosis codes are billed, the algorithm will evaluate each code and other claims information and assign a maximum level of service to each diagnosis. As an example, if there are three diagnosis codes billed in the claim header, two of which are assigned a maximum level of service of three (99213) and one (1), which has an assigned maximum level of service of four (99214), then a level four E&M code is allowed.

The minimum level of service that an E/M code may be reduced to is level three (i.e., 99213) for E/M services with five levels, and to a level two for ophthalmology E/M services (i.e. 92002 or 92012).

Each E/M category (i.e., new visits, established visits, new ophthalmology visits, established ophthalmology visits and office consultations) has its own assigned values.

E/M services will be not be denied as a result of this policy, but E/M services will be reviewed and may be reduced based on the level of service performed.

Coding and Modifier Information

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CPT/HCPCS Code	Descriptor
99204	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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205	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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99214	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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215	Office or other outpatient 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, 40 minutes must be met or exceeded.
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
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.

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	NA

Definitions:

Evaluation and Management Services

Evaluation and Management (E/M) services encompass provider-patient encounters reported for healthcare reimbursement. Per current CMS and AMA guidelines, code selection is primarily determined by Medical Decision Making (MDM) or Total Time spent on the date of the

encounter, rather than the historical 1995/1997 tiered components. E&M codes are based on the Current Procedural Technology (CPT®) codes established by the American Medical Association (AMA®).

Overcoding
Billing procedure codes at higher level than what is warranted by the clinical documentation.

References
1. *Current Procedural Terminology (CPT®)*, 2025.
2. *Centers for Medicare and Medicaid Services,* CMS Manual System and other CMS publications and services.

Revision History	
01/23/2020	Initial Policy Draft
02/06/2020	Final Medical Affairs and Payment Integrity Review, Policy Approved and Watermarks Removed
02/6/2021	Annual Review, updated codes (in accordance w 2021 descriptions) review date and copyright dates
02/6/2022	Conducted annual review, removed product type, confirmed codes, updated review date and copyright dates
02/28/2023	Conducted annual review, confirmed codes and updated descriptions, updated review date and copyright dates
02/26/2025	Conducted annual review and updated dates. Confirmed codes and updated CPT code descriptions 99204, 99205, 99214, 99215 in accordance with 2025 terminology.
04/22/2025	Revised title to add "Office-based" and updated review date, updated language in Policy Overview and removed "hospital observation services", added language under Reimbursement regarding coding validation.
03/25/2026	Annual review. Rewording throughout for clarity. Updated components for selecting level of service; Added guidelines for selecting level of service based on MDM; Added guidelines for selecting level of service based on time; Update definition of E/M services; Updated review and copyright dates. Updated all references from "member" to "member/enrollee."

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.