Notification: Effective June 1, 2025 except in the case of preventive E/M services, Cigna will not separately reimburse CPT® code 99459 when reported with E/M CPT codes 99202 – 99205 and 99212 -99215 as it is considered included in the E/M service

Reimbursement Policy Commercial

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Reimbursement Policy Number..... R30

Evaluation and Management Services

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INSTRUCTIONS FOR USE
*Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also*

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Overview

Evaluation and Management (E/M) codes are used to represent services provided by a physician or other qualified healthcare professional. E/M CPT® codes should reflect the appropriate place of service and be supported within the documentation.

This policy applies to all claims submitted on a Center of Medicare and Medicaid Services (CMS) 1500, UB-04 and all electronic equivalent claim forms.

Reimbursement Policy:

Cigna allows reimbursement for an Evaluation and Management (E/M) services when the following criteria are met:

- E/M services provided must meet the criteria as defined in the current year CPT® E/M guidelines
- Documentation within the medical record must be specific to the patient and the encounter at the time of service. Cloned or "copy and paste" must not be used within the patient documentation. Cigna considers cloned or "copy and paste" identified when the entries in the medical record is worded exactly alike or similar to the previous entries or when the medical documentation is exactly the same within different patient records

Cigna does not reimburse for:

- For outpatient or inpatient consult codes reported by a physician or other qualified healthcare professional on a CMS - 1500
- Professional evaluation and management (E/M) codes for professional services when reported by a facility on a UB-04 claim form. Facilities may report Emergency Department Services CPT® codes 99281 – 99285 for facility emergency room services using the appropriate revenue code (045X)
- CPT® code 99211 when reported with modifier 25 on a CMS - 1500 claim form
- Two E/M service codes submitted for the same date of service on a CMS - 1500 claim form unless the presenting situation is one of the exception scenarios noted below
    1. Prolonged service with direct face-to-face contact (CPT® 99354, 99355)
    2. A preventive medicine office visit (CPT® 99381-99397) with a problem-based office visit (CPT® 99202-99215)

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- E/M services reported with modifier 25 and joint injection codes reported on the same date of service, with a same or similar diagnosis code are not separately reimbursable without documentation supporting the use of Modifier 25 on a CMS - 1500 claim form
- Prolonged service codes 99358 and 99359 reported on CMS - 1500 claim form as they are considered to be included in the overall care of the customer
- When impacted cerumen (CPT® 69209 or 69210) is the sole reason for the visit an E/M service (CPT® 99202-99205 and 99211-99215) is not separately reimbursed on a CMS - 1500 claim form and all electronic equivalents
- Cigna will not separately reimburse E/M services (CPT® codes 99211-99215) reported with a testosterone therapy injection when the injection is the sole reason for the visit
- Except in the case of preventive E/M services, Cigna will not separately reimburse CPT® code 99459 when reported with E/M CPT codes 99202 – 99205 and 99212 -99215 as it is considered included in the E/M service.

General Background

Evaluation and Management (E/M) are services provided by a physician or other qualified healthcare professional. The E/M section of the Current Procedural Terminology (CPT®) book is divided into various categories that are further divided into sub-categories which describe the different E/M service classifications. The various classification consist of the following but not limited to, office/outpatient visits, inpatient hospital visits, etc. The E/M service classification represents the nature of the work which varies by type of service, place of service, patient medical status, code criteria, work completed by the provider.

Medical Record Documentation

The current CPT® evaluation and management section provides documentation guidelines including the definitions of new and established visits. The Centers Medicare & Medicaid Services (CMS) published 2 sets of documentation guidelines the 1995 and 1997 guidelines. Cigna recognizes and follows the CMS 1997 coding documentation guidelines. E/M services provided must meet the criteria as defined in the 2021 CPT® E/M guidelines for code section 99202 – 99215 and CMS 1997 Documentation Guidelines. Clinical documentation must be maintained by the provider which support the services/procedures and must be made available to Cigna upon request.

Documentation within the medical record must be unique to the patient and the encounter for that specific date of service in order to support the E/M code reported. Cloned or copying and pasting from previous encounters is not appropriate. CMS states: "Cloning—this practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in health care institutions that is not broadly addressed. The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable."

Evaluation and Management Service Types

Evaluation and Management codes are identified within the Current Procedural Terminology (CPT®) ranging in various types of services. Some types of service within the section are but not inclusive:

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- Office visits - both established and new with descriptions
- Hospital services – inpatient and observation
- Emergency Room
- Preventive
- Critical Care
- Other codes that are based on location
- The codes contain descriptions and key components: history, examination, and medical decision making which are necessary for code selection

New and Established Patients

Cigna follows American Medical Association (AMA) definitions of what is considered to be a new or established patients.

New Patient

Cigna agrees with the AMA and CMS definition of a new patient; a new patient is one who has not received professional services by the same physician, or another physician within the same practice (group) within the previous 3 years.

Established Patient

Cigna agrees with the AMA and CMS definition of an established patient; an established patient has received professional services by the same physician, or another physician within the same practice (group) within the previous 3 years.

Guidelines for Office or Other Outpatient E/M Services Codes 99202 – 99215

Cigna will follow the guidelines that have been outlined in the E/M guidelines section of the current CPT® code book. Specific requirements for codes are found in the AMA CPT® coding guidelines code book. The guidelines consist of the following areas: History and physical examination, total time, and medical decision making (MDM).

Total Time - The AMA states, "Total time on the date of the encounter (office or other outpatient services [99202 – 99205 – 99212 – 99215]: For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff)."

Note: Time is not a component for the emergency department CPT® codes 99281 - 99285 per the CPT® coding guidelines.

Medical decision making and interpretation and report: "When the physician or other qualified health care professional is reporting a separate CPT® code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making

when selecting a level of office or other outpatient service. When the physician or other qualified professional is reporting a separate service for discussion of management with a physician or other qualified health care professional, the discussion is not counted in the medical decision making when selecting a level of office or other outpatient service."

CPT® code 99211 MDM code levels do not apply.

Guidelines for Additional Codes within the Evaluation and Management Section

The following sections within the Evaluation and Management section continue require a medically appropriate history and/or examination and medical decision making unless otherwise specified. Specifications are in the current AMA CPT® coding guidelines:

- Hospital Inpatient/Observation Services
- Consultations
- Emergency Department Services
- Critical Care Services
- Nursing Facility Services
- Rest Home or Residence Services

Consultation Codes

Consultations services are evaluation and management services that are requested by physician/qualified healthcare professional during the care of a patient to obtain advice, or an opinion of care concerning a specific condition or problem.

Cigna will not reimburse consultation codes office or other outpatient consultation CPT® (99242 – 99245), and 99252 - 99255. Non-consultative Evaluation and Management Codes may be utilized based on the code that best describes the service performed.

Evaluation and Management Codes in the Facility

Cigna will not reimburse professional evaluation and management (E/M) codes when reported by a facility on a UB-04 claim form, except for Emergency Department Services CPT® codes 99281 – 99285 using the appropriate revenue code 045X. The UB-04 is utilized by institutions/facility for ~~billing~~ reporting facility resource utilization.

Multiple Patient Encounters on the Same Day

Cigna does not reimburse two E/M service codes submitted for the same date of service unless the presenting situation is one of the exception scenarios noted below. Generally, the service code with the higher Relative Value Unit (RVU) will be considered for reimbursement.* The CMS Medically Unlikely Edit (MUE) of 2 for codes 99212, 99213 and 99214 is excluded from editing as it conflicts with this reimbursement policy indicating that we only pay 1 E/M service per health care professional per single date of service.

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One exception to reporting multiple patient encounters in one day is that of prolonged services with direct face-to-face patient contact (CPT® 99354, 99355). When appropriate, these codes may be used in conjunction with another E/M code for the same date of service.

Discharge Services

Cigna will reimburse E/M discharge services reported by the primary provider for both inpatient and observation services.

Only one hospital discharge management service is reimbursable per hospital inpatient or observation stay.

Cigna will reimburse specialists or additional providers that use a subsequent E/M code applicable to the type of stay, if providing services on the same day as discharge.

Prolonged Services without Direct Patient Contact

The CPT® manual states "prolonged service is provided that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an evaluation and management service and is beyond the usual physician or other qualified health care professional service time."

Cigna will not reimburse prolonged service codes 99358 and 99359 reported on CMS - 1500 claim form as they are considered to be included in the overall care of the customer.

Coding/Billing Information:

Not separately reimbursed: Evaluation and management (E/M) codes when reported by a facility on a UB-04 claim form

CPT®** Codes	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.
99203	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.
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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

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99211	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.
99212	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.
99213	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.
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 time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
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 time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99221	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.
99222	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.
99223	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.
99231	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.
99232	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.
99233	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.
99234	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.
99235	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.
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.
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 code for primary service)
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, 45 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, 15 minutes must be met or exceeded.
99309	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.
99310	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.
99315	Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
99316	Nursing facility discharge management; more than 30 minutes total time on the date of the encounter
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the

	ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination,

	counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99429	Unlisted preventive medicine service
99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and Completion of necessary documentation/certificates.
99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant
99461	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center
99462	Subsequent hospital care, per day, for evaluation and management of normal newborn
99463	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date
99464	Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn
99465	Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
99466	Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care during transport

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99467	Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; each additional 30 minutes (List separately in addition to code for primary service)
99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services
99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)
99499	Unlisted evaluation and management service

HCPCS Codes	**Description**
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
G0463	Hospital outpatient clinic visit for assessment and management of a patient

Prolonged Services

Not Separately Reimbursed Prolonged Service Codes

CPT®* Codes	**Description**
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour

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99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

Not Separately Reimbursed inpatient and outpatient E/M consultation Codes

CPT®* Codes	Description
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.

Not Separately Reimbursed: E/M with joint injections:

E/M codes 99212, 99213, 99214, 99215 are not reimbursed without documentation supporting the use of modifier 25 when reported with the following joint injection codes with a same or similar diagnosis code on the same date of service.

CPT®* Codes	Description

Notification: Effective June 1, 2025 except in the case of preventive E/M services, Cigna will not separately reimburse CPT® code 99459 when reported with E/M CPT codes 99202 – 99205 and 99212 -99215 as it is considered included in the E/M service

20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

Not Separately Reimbursed: E/M (CPT® codes 99202-99205 and 99211-99215) when reported with the removal of impacted cerumen

CPT®* Codes	**Description**
69209	Removal impacted cerumen using irrigation/lavage, unilateral
69210	Removal impacted cerumen requiring instrumentation, unilateral

ICD-10-CM Diagnosis Codes	**Description**
H61.20	Impacted cerumen, unspecified ear
H61.21	Impacted cerumen, right ear
H61.22	Impacted cerumen, left ear
H61.23	Impacted cerumen, bilateral

Not Separately Reimbursed: E/M services (CPT® codes 99211-99215) when reported with a testosterone therapy injection when the injection is the sole reason for the visit

CPT®* Codes	**Description**
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

HCPCS Codes	**Description**
J1071	Injection, testosterone cypionate, 1 mg
J3145	Injection, testosterone undecanoate, 1 mg

References

1. American Medical Association. Current Procedural Terminology (CPT®) ©2025 Professional Edition.

2. CMS Electronic Health Records Provider, 2015 https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf Accessed 01/19/2023

3. Optum360, Evaluation Management Coding Advisor 2025 (USA: Optum360 ©2024)

4. AMA CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202 – 99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes Effective January 1, 2021 https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf Accessed 01/19/2023

5. AMA CPT® Evaluation and Management (E/M) Code and Guideline Changes, this document includes the following CPT® E/M changes effective January 1, 2023. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf Accessed 12/23/2022

6. American Medical Association. Removal of Impacted Cerumen. CPT® Assistant, vol. 26, no.1, 2016.

7. CGS Administrators, LLC, Local Coverage Determination (LCD): Cerumen (Earwax) Removal (L33945). Accessed 01/23/2023 https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33945&Cntrctr=All&UpdatePeriod=767

8. ICD-10-CM International Classification of Diseases 10th Revision Clinical Modification 2025 American Medical Association (AMA) ©2024

9. American Medical Association (AMA), HCPCS Level II Professional 2024

Policy History/Update

Date	Change/Update
03/04/2025	Notification update for pelvic exam notification date from July 1 to the correct date of 06/01/2025 which align with the communication
02/28/2025	Notification: Effective July 1, 2025 except in the case of preventive E/M services, Cigna will not separately reimburse CPT® code 99459 when reported with E/M CPT codes 99202 – 99205 and 99212 -99215 as it is considered included in the E/M service. Clarifications were added, policy language around the reporting ER services on a UB-04, added language for discharge services
01/10/2025	Updated the policy template, removed the CMS 97 guideline reference and removed the deleted codes from the code list 99201(deleted 2021), 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99241, 99251, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99338, 99340 codes were deleted as of 01/01/2023. Replaced billed with reported
04/16/2023	Effective: Cigna will not separately reimburse E/M services (CPT® codes 99211-99215) when billed with a testosterone therapy injection when the injection is the sole reason for the visit.
01/26/2023	Notification: effective 04/16/2023, Cigna will not separately reimburse E/M services (CPT® codes 99211-99215) when billed with a testosterone therapy injection when the injection is the sole reason for the visit.

Notification: Effective June 1, 2025 except in the case of preventive E/M services, Cigna will not separately reimburse CPT® code 99459 when reported with E/M CPT codes 99202 – 99205 and 99212 -99215 as it is considered included in the E/M service

01/26/2023	Updates based on the 2023 guideline changes, revisions, and deletions. Revisions to code description to codes 99221 – 99223, 99231 – 99239, 99242-99245, 99252-99255, 99281-99285, 99304-99310, 99315, 99316, 99341, 99342, 99347-99350. Notated as deleted: 99217-99220, 99241, 99251, 99318, 99324-99238, 99334-99337, 99339, 99340 and 99343. Updated the reference section to include adding the web address for the LDC of the cerumen removal with access date.
11/29/2022	For clarification added the E/M codes in the coding section for the denial of E/M on a UB04. Code 99201 added a note stating deleted as of 01/01/2021. Updated the reference section.
11/14/2021	When impacted cerumen (CPT® 69209 or 69210) is the sole reason for the visit an E/M service (CPT® 99202-99205 and 99211-99215) is not separately reimbursed on a CMS 1500 claim form and all electronic equivalents. Clarified the statements with the ER adding the code range. Added the R36 to the policy resource list.
09/14/2021	Notification: When impacted cerumen (CPT® 69209 or 69210) is the sole reason for the visit an E/M service (CPT® 99202-99205 and 99211-99215) is not separately reimbursed on a CMS 1500 claim form and all electronic equivalents effective 11/14/2021.
04/29/2021	Correct the Prolonged service codes to reflect codes 99358 and 99359.
02/02/2021	Revision to policy based on the 2021 CPT® coding guidelines within the E/M section. Removal of code 99201 due to deletion of code as of 01/01/2021. Added prolonged service statement on codes 99358 and 99359. Clarifying wording on some of the sections. Updated reference section and related policy section.
10/06/2020	Added policy statement for cloning and coping and pasting within the medical record documentation section. Clarification and wording within policy. Updating of the resource section.
05/12/2020	Updated reference section and changed reimbursement to reimburse in the reimbursement policy section.
03/16/2020	Effective date: Evaluation and Management codes 99212 – 99215 appended with modifier 25 will not be reimbursed without documentation supporting when billed with injection codes 20600, 20604, 20605, 20606, 20610, and 20611. Denial of code 99211 when billed with modifier 25. Also added the hospital discharge management codes 99238 – 99239.
02/26/2020	Revised wording for E/M with injection policy statement.
12/17/2019	Notification of Evaluation and Management codes 99212 – 99215 appended with modifier 25 will be denied when billed with injection codes 20600, 20604, 20605, 20606, 20610, and 20611. Denial of code 99211 when billed with modifier 25. Also added the hospital discharge management codes 99238 – 99239.
10/19/2019	Effective Date of denial of Consultation Codes.
07/18/2019	Notification for Consultation Codes not reimbursable effective 10/19/2019

Notification: Effective June 1, 2025 except in the case of preventive E/M services, Cigna will not separately reimburse CPT® code 99459 when reported with E/M CPT codes 99202 – 99205 and 99212 -99215 as it is considered included in the E/M service