Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Evaluation and Management

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☐ Tufts Health Plan Commercial products

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan
☐ Tufts Health One Care – A dual-eligible product

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☐ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Harvard Pilgrim reimburses contracted providers for the provision of evaluation and management (E&M) services.

Prerequisites

Applicable Point32Health referral, notification, and authorization policies may apply. Refer to the appropriate sections within the Provider Manuals for more information.

General Benefit Information

Services are pursuant to the member's benefit plan documents and are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible). Member eligibility and benefit specifics should be verified prior to initiating services.

Use of non-contracted labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Point32Health may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Point32Health Reimburses

Multiple E&M Services- Same Day

When multiple providers within the same billing group (using the same federal tax identification number) and of the same specialty/subspecialty perform E&M services (outpatient or inpatient) on the same patient, on the same day, Harvard Pilgrim will reimburse only the E&M service with the highest allowable amount, regardless of whether the visits are related or not.

~~Only one E&M service (outpatient or inpatient) will be reimbursed per date of service when providers using the same federal tax identification number and of the same specialty/subspecialty, regardless of whether the visits are related or not.~~

- Example: A member is seen in the hospital by internal medicine physician with a subspecialty of gastroenterology for hypovolemia and is also seen for septicemia by another internal medicine physician with a subspecialty of infectious disease within the same group.

Preventive Visit and Problem-Oriented Visit- Same Day

Harvard Pilgrim will reimburse a preventive visit and a problem-oriented visit when the 25 modifier is applied to the problem-oriented visit. Reimbursement for the higher valued service will be made at 100% of the contracted allowable rate, and reimbursement for the lower valued service will be made at 50% of the contracted allowable rate.

Addressing a problem abnormality during a preventive visit is considered part of the preventive visit; a problem-oriented visit should only be reported when there is a significant problem or abnormality addressed and there is additional work required to perform the key components of a problem-oriented E&M service. The medical record documentation must support both services.

- If both the preventative and problem-oriented visit is provided to a new patient (as defined by CPT), bill the preventive service with the age appropriate “new patient” CPT code, and the problem-oriented visit as “established patient.”

Significant, Separately Identifiable E&M with Global Service- Same Day

Policy applies to all professional services performed in an office place of service - when significant, separately identifiable E/M service (appended with 25 or 57 modifier as applicable) and any service that has a global period indicator as designated by CMS of 0, 10, 90 or YYY is performed on the same day, the E&M service will be reimbursed at 50% of the contracted allowable. When the E&M RVU value is greater than the procedure, the reduction will be applied to the global procedure code.

New Patient Visits

New patient visits are reimbursed when the physician/qualified health care professional, or another physician of the same specialty within the same group, has not seen the patient for three years.

Certification of Home Health Services

Physician certification and recertification of home health services are reimbursed for Medicare covered services provided by a home health agency.

Genetic Counseling

When medically necessary, genetic counseling requires a referral from the member’s PCP. The PCP should always refer the member to a Harvard Pilgrim–contracted provider for services.

Emergency Department Care

E&M services rendered at a hospital for unscheduled episodic care to patients who present for immediate medical attention. (The facility must be open 24 hours a day.)

Critical Care

Critical care services are reimbursed in accordance with, but not limited to, the CPT definition.

- 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 patient’s care.

Services rendered to a non-critical patient located in a critical care unit will be reimbursed using the appropriate E&M code.

Pediatric and Neonatal Intensive Care

Pediatric and neonatal intensive care services are reimbursed in accordance with CPT definition.

Patient Transport

Attendance and direct face-to-face care by a physician during an inter-facility transport of a critically ill or critically injured child, if the total time is greater than 30 minutes.

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 (e.g., emergency room, doctor’s office).

Physician Home Visit

Harvard Pilgrim reimburses physician home visits.

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, President’s Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Thanksgiving Day, and Christmas Day.

Collaborative Care

Collaborative care services are reimbursed when provided under the direction of a treating physician or other qualified health care professional that identifies a member’s behavioral health needs and integrates care management support and regular psychiatric inter-specialty consultation with the primary care team during a calendar month. When billing collaborative care services delivered during the calendar month use the last date that the collaborative care service was performed in the month as the DOS on the claim form. Claims must be submitted after the services have been rendered in the entire month.

- 99492: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
- 99493: Follow up psychiatric collaborative care management, first 60 minutes in a following month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
- 99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional directs. (use 99494 in conjunction with 99492,99493)
- G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

Point32Health Does *Not* Reimburse

- A non-direct patient service or a service where the patient is not present.
- Adjunct codes reported in addition to basic services CPT codes 99051-99060.
- After-hours services provided in the office during regularly scheduled evening, weekend, or holiday office hours.
- Airway inhalation treatment when billed with inpatient E&M codes.
- Analysis of data stored on a computer.
- Consultation services
- CPT 99211, with or without modifier 25 when billed on the same day as a chemotherapy administration service, a non-chemotherapy drug infusion or a drug injection service.
- E&M services on the same day as a surgical procedure unless it is a significant and separately identifiable service, *or* it is above and beyond the usual preoperative and postoperative care associated with the procedure and the correct modifier is appended.
- Electronic visits (e-visits).
- Generic supplies (A specific HCPCS code must be submitted for reimbursement consideration.)
- Handling fees, device handling, or telephone E&M services.
- Hospital-mandated on call service, in hospital or out of hospital.
- Medical and surgical supplies and/or items, such as, but not limited to, syringes, needles, local anesthetic, saline irrigation, dressings or gloves when billed in the office location.
- Medical conferences by a physician with an interdisciplinary team of health professionals to coordinate care of a patient when the patient is not present.
- Medical testimony.
- Physician standby services.
- Pre-operative surgery clearance if the same PCP has been reimbursed for an E&M visit to his/her own patient for the same or related condition or diagnosis.
- Prolonged service. (This may be reimbursed only after individual consideration which is based on the medical documentation).
- Provider travel time and/or expenses.
- Services defined by CPT as included in the definition of patient transport codes.
- Venipuncture charges (collection of blood) made in conjunction with blood or related laboratory services or evaluation and management service when reported on the same day by any provider reporting the same Federal Tax ID Number (TIN).

Provider Billing Guidelines and Documentation

Providers are reimbursed according to the applicable contracted rates and fee schedules.

Coding

Code	Description	Comments
36620	Insertion of an arterial catheter	Separately reimbursed when billed with an emergency department E&M service
94640	Airway inhalation treatment	Not reimbursed when billed with an inpatient E&M service
99173	Screening for visual acuity	Not reimbursed with an E&M service
99401-99404,	Preventive medicine counseling (separate	Not separately reimbursed when billed with a

Code	Description	Comments
99411-99412	procedure)	preventive exam or a problem-oriented E&M service
99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time	Not reimbursed; may be appealed for reimbursement after individual consideration of medical record documentation
99418	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service	Not reimbursed; may be appealed for reimbursement after individual consideration of medical record documentation
G0102	Prostate cancer screening; digital rectal examination	Not separately reimbursed when billed with an E&M service or when billed by a facility
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	Not reimbursed; may be appealed for reimbursement after individual consideration of medical record documentation
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified health care professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services.) (Do not report G2212 on the same date of service as codes 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)	Not reimbursed; may be appealed for reimbursement after individual consideration of medical record documentation

Preventive Medicine Services with Screening and other Evaluation and Management Services

Preventive medicine involves conducting a history and examination tailored to the member's age and gender. The initial and routine comprehensive preventive medicine examinations also include counseling, anticipatory guidance, and interventions aimed at reducing risk factors.

Effective for dates of service on or after June 1, 2026, the following services will not be reimbursed separately if billed on the same day as a preventive medicine service (CPT codes 99381 to 99387, 99391 to 99397, and HCPCS code G0402), as these services are considered to be part of the preventive medicine visit:

Service	Code
Annual gynecological exam	S0610, S0612, S0612
Annual wellness visit	G0438, G0439
Counseling services	0403T, 99401, 99404, 99406-99409, 99411-99412, G0286, G0396, G0397, G0443, G0445-G0447, G0473, H0005, S0257, S0265, S9470, T1006, T1027
Medical nutrition therapy services	97802-97804, G0270-G0271
Other E&M services	99211, 99242-99245, 99252-99255, 99281, 99285, G0426, S0285
Prolonged services	99415-99418, G0316-G0318, G2212
Screening services	G0101-G0102, G0442, G0444, Q0091
Visual function and acuity screening	0333T, 99172

Note: appending modifier(s) 25, 59 ,XE, XP, XS, or XU to these services will not result in separate reimbursement.

Other Information

- When the patient's condition requires a significant, separately identifiable E&M service, the appropriate modifier ~~25~~ should be appended/reported. The E&M service must be above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure performed.
- For E&M services that are unrelated to the original procedure during the postoperative period modifier 24 should be appended/reported.
- For time-based services, including prolonged services, medical record documentation must include total time. This includes face-to-face time and non-face-to-face time. If there is face-to-face time and non-face-to-face time that occurs several times during the same date of service for the same member, total time needs to be clearly documented.

Related Policies and Resources

Payment Policies

- Anesthesia
- Emergency Department Services
- Home Health Care
- Hospital-based Clinic
- Modifiers
- Non-Covered Services
- Surgery
- Telemedicine/Telehealth

Clinical Policies

- Genetic and Molecular Diagnostic Testing
- Home Health Care

Publication History

04/01/2026: Policy moved to new template; added language for screening services with related E&M services effective for DOS beginning June 1, 2026; updated related policies and resources

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.