curative

TITLE:	EVALUATION AND MANAGEMENT SERVICES
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	12/15/2025
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows in regard to this P&P.

3.1. **Evaluation and Management (E/M) Services** Face-to-face and/or non-face-to-face provider work involving history, examination, medical decision-making (MDM), and/or time, as defined by CPT®.

3.2. **Medical Decision Making (MDM)** The complexity of establishing a diagnosis and/or selecting a management option, considering the number/severity of problems, data review/analysis, and risk of complications.

3.3. **Modifier 25** Indicates a significant, separately identifiable E/M service by the same provider on the same date as another procedure or service.

3.4. **Prolonged Services** E/M codes reported for time spent beyond the typical service time for a given CPT® code, using specific add-on codes.

3.5. **Same Individual Provider** The same individual Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification number.

3.6. **Same Group Practice** Physicians and/or Other Qualified Health Care Professionals of the same specialty reporting the same Federal Tax ID number.

3.7. **Same Specialty Provider** Physicians and/or Other Qualified Health Care Professionals of the same group and same primary specialty reporting the same Federal Tax Identification number.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered

must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Reimbursement Guidelines

This policy outlines how Curative determines reimbursement for Evaluation and Management (E/M) professional services. Guidelines established by the American Medical Association, AMA, within the Current Procedural Terminology (CPT®) Evaluation and Management coding guidelines.

Providers should choose the code that best describes the service rendered based on the corresponding sections and subsections of the CPT® book, AMA guidelines as well as CMS documentation guidelines. The different sections of E/M codes vary by the type of service, place of service, the amount of provider work, the documentation required as well as the patient's medical status, and other code criteria. The necessary key components of documentation appear in the E/M code descriptors and many code categories address increasing levels of complexity.

Providers have the option to base the E/M level of care on Time or Medical Decision Making. The codes eligible to be based on time are: Office and Outpatient Evaluation and Management (99202-99205, 99211-99215), Inpatient and Observation E/M Visits (99221-99223, 99231- 99239), Consultation Codes (99242-99245, 99252-99255), Emergency Department Services codes (99281-99285), Nursing Facility Services codes (99304-99310, 99315, 99316), Home or Residence Services codes (99341-99345, 99347-99350). Codes not eligible to be determined by time are Emergency Services codes (99281-99285).

Selecting the Level of Service Based on Time

Time documentation criteria for time spent face-to-face or non-face-to-face may include, but not limited to:

1. Examination/Evaluation
2. Counseling/Education of patient, family, caregiver performed by the provider only
3. Prep time for patient history/test reviews

4. Documentation/Interpretation
5. Care Coordination/Referring and Communication with other health care providers
6. Orders for tests, procedures, and medication. Time documentation criteria for time spent face-to-face or non-face-to-face may not include:
    a. Time spent by clinical staff
    b. Patient wait time for physician or other health care providers
    c. Performance of other services or procedures provided the same day as the evaluation and management service

Selecting the Level of Services Based on Medical Decision Making (MDM)

Medical Decision Making of straightforward, low, medium, or high are determined by the following:

1. Number and complexity of problem addressed

2. Amount and/or complexity of data reviewed and analyzed

    a. Orders for, and interpretation of data from a test or image cannot be included when determining the E/M level of service if the test or image interpretation is billed separately

3. Risk of complications and/or morbidity or mortality of patient management

Two of the three elements required for a particular code designation must be met or exceeded as outlined in the CPT codebook. Additional information regarding the code selection based on Time or MDM and the requirements for each can be found in the most current edition of the American Medical Association CPT codebook.

New Patient or Established Patient Status for Office Evaluation and Management Visits:

"New" Patient - a patient not seen by the same provider/group/specialty in the past 3 years.

"Established" Patient - a patient seen by the same provider/group/specialty within the past 3 years.

Same Group Practice is defined as physicians and/or other qualified health care professionals of the same primary specialty reporting the same Federal Tax ID number.

Same specialty is defined by primary specialty. Subspecialties are not taken into consideration when determining eligibility for reimbursement.

Reimbursement for multiple Evaluation & Management (E/M) codes performed for the same member by the same provider or group practice will be limited to one E/M service per date of service using the appropriate code level representative of the cumulative related services. This applies to E/M categories defined by levels of service. Please reference CPT® and HCPCS manuals for a complete listing of E/M categories.

Problem oriented E/M services performed for the same member by the Same Individual Provider or Same Group Practice on the same day as preventative visits (99381-99387, 99391-99397) require a Modifier -25 identifying the service as separate. The problem oriented service is appropriate only when the problem or abnormality is significant and separately identifiable enough to require additional work beyond the preventive service. The documentation must support the service and the diagnosis should reflect the non-preventative nature.

Screening services performed for the same member by the Same Individual Provider or Same Group Practice on the same day as preventative medicine and/or problem-oriented E/M services are not eligible for separate reimbursement regardless of Modifier 25 usage.

New Patient or Established Patient Status for Emergency Department Visits:

Providers must use CPT codes 99281-99285 for emergency department visits for both established patients and new patients for the emergency department visit. CPT codes 99281-99285 are only appropriate when services are provided in an emergency department as defined by AMA CPT; “an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day,” and “organized based facility” includes hospital owned free-standing emergency departments.

If documentation is requested and it is determined it does not support the level submitted or the location of the service, adjustments, or denials of the E/M code reported may occur. The provider may resubmit the claim with a revised E/M code for denied claims.

Other examples of Curative Health will deny or reduce payment for E/M services when:

a. Documentation does not support the CPT® code billed
b. Modifier 25 is appended without medical necessity
c. The service is bundled into a procedure’s global period
d. The E/M is part of routine post-op care and within the global period without modifier 24
e. Multiple E/Ms are billed for the same patient/same day without clear medical necessity for each
f. Telehealth encounters fail to meet regulatory or technical requirements

Curative Health reserves the right to conduct prepayment and postpayment reviews, especially for high-level codes (99204–99205, 99214–99215, 99244–99245).

Excessive use of modifiers or high-level E/Ms may prompt chart requests.

Noncompliance may result in recoupment, claim denial, or provider education requirements.

5. REFERENCE DOCUMENTS AND MATERIALS

5.1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

5.2. Centers for Medicare and Medicaid Services, CMS Manual System, and other CMS publications and Novitas Solutions – Medicare Part B: “Evaluation & Management Services: Medical Decision Making

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Compliance

6.3. Medical Management

6.4. Network

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
12-15-2025	CJ Wisecarver	001	Initial Version