MEDICAID REIMBURSEMENT POLICY

Online Digital Evaluation and Management Services

Active

Section: Evaluation and Management Service
Policy Number: 014
Effective Date: 04/01/24

Description

This policy addresses coding and reimbursement for online digital evaluation and management (E/M) services (e-Visits).

Definitions

Electronic Visit (e-Visit): A patient-initiated service using an online portal for communication.

Policy Statement

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will reimburse for online digital E/M services provided to an established patient.

E-Visits may be billed using Current Procedural Terminology (CPT®) codes 98970-98972 when services are provided by a nonphysician qualified health care professional (QHP), or codes 99421-99423 when services are provided by a physician or other QHP.

These services require a clinical decision that typically would have been provided in the office (eg, medication dose adjustment, ordering of a test, or prescription of a new medication). The routine dissemination of test results, processing of medication requests, or scheduling of appointments are not reimbursed separately.

These services are not reported if related to a surgical procedure or within the postoperative (global) period of a procedure. Online digital E/M services include the cumulative time needed to evaluate, assess, and manage the patient within a seven-day period by the reporting physician or other QHP in the same group practice.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only

codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A					
ICD-10 Diagnosis:	N/A					
ICD-10 Procedure:	N/A					
CPT/HCPCS:	98970	98971	98972	99421	99422	99423
Revenue Codes:	N/A					

Resources

Current Procedural Terminology (CPT®)
CPT® Assistant

Policy History

01/23/2024	Initial Committee Approval