

## 11. 1 Payment Initiative: Problem Oriented Evaluation and Management Visit (E&M) Billed with a Preventative Visit

### Policy Overview

Pursuant to Modifier-25 coding requirements, a physician may furnish a preventive evaluation and management (E&M) service and a problem-oriented E&M service during the same encounter when the clinical circumstances warrant distinct and separately identifiable work. Duplicate reimbursement is considered to occur when payment is issued for resources or activities not directly attributable to the person whom received the services.

This policy establishes the criteria governing reimbursement for problem-oriented E&M services submitted concurrently with preventive services. These standards are intended to ensure consistent claims adjudication, prevent inappropriate payment, and support uniform administration of member benefits.

### Reimbursement

Providers do not incur duplicate indirect expenses associated with the provision of a preventive evaluation and management (E&M) service when a problem-oriented E&M service is rendered on the same date of service. Indirect practice expenses—such as the collection of vital signs, scheduling and registration activities, staffing, facility lighting, and examination room preparation—are incurred once per encounter and are not attributable separately to each E&M service. Accordingly, reimbursement for these indirect components shall not be duplicated under any circumstances.

As such, the health plan will issue reimbursement for the preventive medicine service at the full allowable amount and will reimburse the problem-oriented E&M code at 50 percent of the applicable allowable rate. This reimbursement methodology is intended to ensure compliance with coding regulations, prevent inappropriate duplicate payment, and promote consistent and equitable claims adjudication.

### Coding Information

Preventative Code Set		Problem Oriented Code Set	
99381	99382	99202	99203
99383	99384	99204	99205
99385	99386	99212	99213
99387	99391	99214	99215
99392	99393	G0463	
99394	99395		
99396	99397		
G0402			

### Exemptions

Federally Qualified Health Centers and Rural Health Centers will not be subject to a 50% reduction to problem oriented E/M visits when reported on the same day as preventative/wellness exams.

Policy History	
3/1/2026	Implemented with dates of service 3/1/2026 to present.

## 11.2 Payment Initiative: Psychotherapy add-on codes

### Policy Overview

This policy establishes the criteria governing reimbursement for CPT codes 90833, 90836, and 90838, which by definition, are to be billed in conjunction with an Evaluation and Management (E&M) code.

Reimbursement will be issued by Blue Cross Blue Shield of Arizona Health Choice only when the medical record contains clear and sufficient documentation establishing the medical necessity of the extended service time and the face-to-face encounter with the patient.

### Reimbursement

The appropriate E&M code must be selected based on the level of work performed, as defined by the key components of history, examination, and medical decision-making. Time alone may not be used as the basis for E&M code selection.

When psychotherapy services are rendered on the same date as an E&M service, an applicable psychotherapy add-on code must be reported to indicate that both services were provided. The documented psychotherapy time must correspond to the CPT code billed, as outlined below:

CPT Code	Time
90833	30 Minutes
90386	45 Minutes
90838	60 Minutes

Time spent performing the medical E&M service may not be included when determining the timed psychotherapy code.

### Coding Information

E&M Codes		Psychotherapy Add-on Codes	
99204	99205	90833	90836
99214	99215	90838	

Policy History	
3/1/2026	Implemented with dates of service 3/1/2026 to present.

### 11.3 Payment Initiative: Sepsis DRG Reimbursement

#### Policy Overview

This policy establishes the criteria governing reimbursement for inpatient claims based on applicable Diagnostic Related Group (DRG), Medicare Severity (MS-DRG) or All Patient Refined Diagnosis Related Groups (APR-DRG) that by definition are Sepsis. Inpatient admissions for the following DRGs, MS-DRG 870 & 871 and APR-DRG 720-3 & 720-4, with a length of stay of three days or less and a discharge status of home (01) or a skilled nursing facility (03) may be denied.

In many instances, these cases represent a “rule-out” for sepsis and are more accurately attributable to dehydration, urinary tract infection, or another diagnosis that should be reported accordingly. Blue Cross Blue Shield of Arizona Health Choice will accept a sepsis diagnosis when accompanied by an appropriate discharge status code for patients who expire or are transferred to another facility or hospice, provided the inpatient stay is three (3) days or fewer and the diagnosis of sepsis is supported.

#### Reimbursement

Claims submitted with a sepsis diagnosis are subject to pre-payment review. Blue Cross Blue Shield of Arizona Health Choice will request medical records to validate the diagnosis and procedure codes reported. Upon receipt, certified professional coders and registered nurses will conduct a clinical validation review to ensure that the medical record contains all required documentation and that the sepsis diagnosis billed is fully supported by the clinical information and medical interventions reflected in the record.

#### Coding Information

MS-DRG		APR-DRG	
870	871	720-3	720-4

Policy History	
3/1/2026	Implemented with dates of service 3/1/2026 to present.