REIMBURSEMENT POLICY STATEMENT
Georgia, Indiana, Ohio, West Virginia Marketplace

Policy Name & Number	Date Effective
Evaluation and Management (E/M) and Psychotherapy Add-On-MP-PY-1776	06/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Evaluation and Management (E/M) and Psychotherapy Add-On

B. Background
An Evaluation and Management (E/M) service is a particular medical service provided by qualified healthcare professionals to evaluate a patient's health status, assess condition, establish diagnoses, and manage care, which includes guiding treatment plans. The difference between a regular and a high-level E/M code primarily relates to the complexity of care, the extent of the evaluation and the intensity of medical decision-making performed during the encounter. These differences are reflected in the documentation requirements and the corresponding CPT codes used for billing.

When a provider, based on tax identification number (TIN), performs both E/M and psychotherapy on the same date of service (DOS) for a member, the 2 services must be coded correctly. Psychotherapy sessions often include some evaluation components. To address the potential overlap, add-on psychotherapy codes are used in addition to E/M services for these visits. Add-on psychotherapy services must be documented, requiring start/stop times specific to the service and any therapeutic communication that ameliorates mental and behavioral symptoms, modifies behavior and support, and encourages personal growth as treatment for behavioral disturbances or mental illness.

C. Definitions
NA

D. Policy
I. When psychotherapy add-on codes 90833, 90836 or 90838 are billed concurrently with high-level E/M codes 99204, 99205, 99214 or 99215 on the same date of service for the same member by the same provider based on the provider tax identification number (TIN), the add-on psychotherapy codes will be denied. The E/M portion of the claim will be reimbursed. Due to the complexity and cognitive demands of moderate to high complexity Medical Decision Making (MDM), it is unlikely that the clinical effort required to complete both E/M and psychotherapy services would not overlap.
   A. Providers are responsible for the appropriate use of add-on codes, billing with modifiers, including use of modifier 25, and interactive complexity. CareSource may request documentation that supports submitted claims.
   B. Service documentation must ensure that psychotherapy and E/M services are clearly documented, substantial and significant, and independently identifiable. Overlapping time spent in an encounter cannot be counted toward both services.

II. The type and level of E/M service is based on MDM. Please see the *American Medical Association (AMA) CPT® Evaluation and Management (E/M) Services Guidelines* for additional instructions.

A. Time spent on the activities of the E/M service is not included in the time used for reporting the psychotherapy service. E/M documentation must support the level of service based on *AMA Medical Decision-Making Guidelines*.
B. Time may not be used as the basis of E/M code selection and prolonged services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported.

E. Conditions of Coverage

The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.

CPT Code	Description
90833	Psychotherapy, 30 minutes with patient when performed with an E/M service.
90836	Psychotherapy, 45 minutes with patient when performed with an E/M service.
90838	Psychotherapy, 60 minutes with patient when performed with an E/M service.
99204	Office or other outpatient visit for the E/M of a new 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, 45 minutes must be met or exceeded.
99205	Office or other outpatient visit for the E/M of a new 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, 60 minutes must be met or exceeded.
99214	Office or other outpatient visit for the E/M of an 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, 30 minutes must be met or exceeded.
99215	Office or other outpatient visit for the E/M of an 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, 40 minutes must be met or exceeded.

F. Related Policies/Rules

Modifier 25

G. Review/Revision History

	DATE	ACTION
Date Issued	03/11/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	06/01/2026	
Date Archived		

H. References

1. *CPT® Evaluation and Management (E/M) Services Guidelines.* American Medical Association. Accessed February 23, 2026. www.ama-assn.org

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.