



# Evaluation and Management Payment Policy

## **Policy**

Fallon Community Health Plan (FCHP) will reimburse for medically necessary Evaluation & Management (E&M) services. FCHP recognizes CPT's definitions of services pertaining to E&M services and follows the 1995/1997 documentation guidelines for E&M services. Medical records may be requested for review to ensure appropriate documentation of services rendered and accuracy of coding. Services and subsequent payments are based on the member's benefit plan document. Eligibility and benefit specifics should be verified prior to initiating services.

## **Definition**

This policy applies to FCHP's payment of professional E&M services.

## **Benefits application**

### **Commercial**

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

### **Senior Plan**

- Fallon Senior Plan™
- Fallon Senior Plan Preferred

## **Reimbursement**

Coverage is limited to those E&M services physicians and qualified non-physician practitioners are legally authorized to perform in accordance with state law. Reimbursement for physician assistants, nurse practitioners and nurse midwives will be made according to the policies, *Nurse Practitioner/Physician Assistant Payment Policy* (ADM0040) and *Nurse Midwife Payment Policy* (ADM0028). All claims are subject to auditing edits.

## **Referral/notification/preauthorization requirements**

Preauthorization requirements do not apply when services are rendered within the member's network.

## **Billing/coding guidelines**

### *Level of E&M service reported*

The E&M service must be coded to the appropriate service level rendered and medically necessary. Medical records must support reported levels of service based on the 1995/1997 documentation guidelines.

#### *New patient definition*

FCHP follows the American Medical Association's definition of a new patient as one who has not received any professional services from the same provider, or another provider of the same specialty who belongs to the same group practice (same tax ID), within the past three years. FCHP will deny subsequent new patient visits and suggest an established patient visit code. Providers may re-bill the service within 120 days from the Remittance Advice Summary (RAS).

#### *Multiple E&M services on the same day*

- FCHP allows one E&M code per day of service per physician group, per specialty regardless of the places of service.
- FCHP does not reimburse for a problem-focused office visit procedure (99201–99215) when billed with a preventive medicine procedure code (99381-99387; 99391-99397).

#### *E&M Services provided with an Office/Outpatient Procedure*

- FCHP does not allow the separate reimbursement of E&M services **when** a substantial diagnostic or therapeutic procedure is performed. Append modifier 25 to the E&M service code when a significant, separately identifiable E&M service above and beyond the usual pre and post procedure care has been rendered by the same physician on the same day as the procedure. The "usual care" for the typical patient is **already covered** by the procedure.

#### *E&M Services provided with lab collection and screening services*

- FCHP will not reimburse separately for G0102 (manual rectal neoplasm screening) when billed along with a preventative medicine service (99381-87; 99391-97) regardless of location.
- FCHP will not reimburse separately for 36415 (collection of venous blood by venipuncture) and/or 36416 (collection of capillary blood specimen i.e., finger, heel, ear stick) when billed along with an E&M office visit (99201-05; 99211-15) or preventative medicine service (99381-87; 99391-97) or office-based lab CPT codes (i.e. CLIA waived tests).
- FCHP will not reimburse separately for 99000; 99001 (lab specimen handling services) when billed with an E&M office visit (99201-05; 99211-15) or preventative medicine service (99381-87; 99391-97).
- FCHP will reimburse 36415 when it is the sole service provided.
- FCHP will reimburse 36416 when it is the sole service provided.

#### *E&M services provided within global period*

Based on the CMS global surgical period:

- FCHP *does not* separately reimburse for any E&M service when reported with *major surgical procedures (90-day global surgical period)*
- FCHP *does not* separately reimburse for any E&M service when reported with *minor procedures with a 10-day post-op period.*
- FCHP *does* separately reimburse for new patient E&M services and E&M services described in CPT as applying to new or established patients (e.g., E&M services for Initial Inpatient Consultations 99251-99255 are described by CPT as applying to new or established patients) when reported with *minor procedures with a 0-day post-op period.*

- FCHP will consider reimbursement for services rendered during the global period if the appropriate modifier -24 is appended to the E&M procedure code and medical notes are included.

*Consultations codes*

99241-99245 (Office/Outpatient)

99251-99255 (Inpatient)

*Documentation guidelines*

1. The consultation CPT codes (99241-99245; 99251-99255) can only be used if the consult was requested by another provider either oral or written. Example: Mary Smith referred for consultation by Dr. Thomas Jones.
2. Written documentation that a request for consultation occurred including the name of referring provider.
3. Evidence of written reply back to the referring provider with a summary of findings (office). Note: In a clinic, facility or inpatient setting where there is a **shared medical record**, the consultative provider does not need to provide a separate note or letter back to the referring/requesting provider. Documentation of findings within the shared patient medical record will be sufficient.
4. In the inpatient setting, one consultation is permitted per admission, per specialty.
5. Please remember to select a CPT code based on the status of the presenting problem(s) today and what will be required to appropriately review and manage the patient's condition today. Documentation alone without sufficient medical necessity to support the extent of the discussion will not in and of itself support the levels of codes provided below.
6. Time: If 50% or more of the total visit time was spent in a medically necessary discussion, then you must document time spent. Example: "15/20 minutes were spent on ..." and provide a brief summary of what supported the extent of discussion noted.
7. Follow-up services that are not a result of another request for consultation must be billed as established E&M office visit codes.

*Consultation CPT codes require the following elements of documentation.*

<u>CPT code</u>	<u>HPI</u>	<u>Exam</u>	<u>Medical decision making</u>	<u>Time</u>
99241/51	1 present factor	1 body area/system	Straightforward	99241=15 min 99251=20 min
99242/52	1 present factor 1 review of system	2-7 "limited" review	Straightforward	99242=30min 99252=40min
99243/53	4 present factors 2-9 review of system 1 past, family, or social	2-7 "extended" review	Low	99243=40min 99253=55min
99244/54	4 present factors 10 review of system 3 past, family, & social	8 body systems	Moderate	99244=60min 99254=80min
99245/55	4 present factors 10 review of system 3 past, family, & social	8 body systems	High	99245=80min 99255=110min

*Definition of "limited vs. extended" exam*

- Limited is defined as the review of 2-4 body areas or systems **with elements of exam noted** OR 2-7 body areas and/or systems listed with only a notation of normal.
- Extended is defined as the review of 5-7 systems **each with elements of exam noted**. Note: 5 body areas or systems reviewed with only a notation of normal will not be considered an extended review of those areas/systems.

*RN and qualified ancillary staff - billable E&M services*

Providers can bill 99211 for RNs or qualified ancillary staff that is employed by a physician's office as follows:

- When the patient visit is a part of an established physician care plan requiring follow-up and is deemed medically necessary.
- RNs or qualified ancillary staff **cannot code higher than a 99211** for E&M services regardless of the time spent or level of services provided.
- RNs or qualified ancillary staff cannot bill new problems or new patient visit code 99201.
- A provider **and** an RN or qualified ancillary staff cannot both bill for an E&M office visit **within the same day**. Only **one** E&M service per day can be billed by **one** provider type.

*Examples of office/clinic visits generally billable using 99211:*

- Patient recently placed on a new medication which causes weight gain. A follow-up visit is scheduled for weight check.
- A blood pressure evaluation for an established patient whose physician requested a follow-up visit to check blood pressure.
- Refilling medication for a patient whose prescription has run out; however, patient must be present in office suite and physically seen by the provider.
- Discussion with patient in-person following laboratory tests results that indicate the need to adjust medications or repeat order of tests.
- Suture removal following placement by a **different** physician/physician group.
- Visit for instructions/patient education on how to use a peak flow meter and other devices.
- Diabetic counseling.
- Dressing change for an abrasion/injury.

*Examples of services generally not billable using 99211:*

- Blood draw only - should be billed using CPT 36415 or 36416.
- Laboratory tests - the lab performing the test should bill the appropriate codes.
- Monitoring of cardiology tests, such as thallium stress tests, where such monitoring is inherent in the performance of the test.
- Injection of therapeutic and/or diagnostic medication - use CPT drug administration code and drug supply code (J code). Note: Part D drugs include the administration fee and must be billed directly to Medicare plan.
- Vaccinations/Immunizations - bill immunization CPT code (e.g., Flu 90658) and administration CPT code only (e.g., 90471).

*Services rendered in the office after-hours or on weekends or holidays*

- FCHP reimburses CPT Code 99050 for services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g. holidays, Saturday or Sunday), in addition to basic service.
- FCHP reimburses CPT Code 99051 for services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

*Critical care services*

FCHP reimburses for only one critical care or intensive care procedures for a single date of service. If multiple services are provided within the same physician group within the same specialty, subsequent submittals will be denied.

Critically ill is defined as a critical illness or injury that acutely impairs one or more vital organ systems indicating a high probability of imminent or life threatening deterioration in the patient's condition.

The following procedures/services are included in reporting critical care when performed during the critical period and, therefore, should not be coded separately. Please see CPT for specific code definitions. 36000, 36410, 36415, 36540, 36600, 43752, 71010, 71015, 71020, 91105, 92953, 93561, 93562, 94002, 94003, 94004, 94660, 94662, 94760, 94761, 94762, 99090.

*Provider billing guidelines*

<b>CPT Codes</b>	<b>Description</b>	<b>Comments</b>
93784, 93786, 93788, 93790	Ambulatory blood pressure monitoring	
99000, 99001	Handling fees	Not separately reimbursed.
99002	Device handling	Not separately reimbursed.
99026, 99027	Hospital-mandated on-call service, in or out of hospital	Not separately reimbursed.
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g. holidays, Saturday or Sunday), in addition to basic service.	Separately reimbursed when submitted with 99201-99205; 99211-99215.
99051	Services provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to basic service.	Separately reimbursed when submitted with 99201-99205; 99211-99215.
99053	Services provided between 10 PM and 8 AM at a 24 hour facility in addition to the basic service.	Not separately reimbursed.
99056	Services typically provided in the office, provided out of the office at the request of the patient, in addition to the basis service.	Not separately reimbursed.
99058	Office services provided on an emergency basis in the office which disrupts other scheduled office services, in addition to the basic service.	Not separately reimbursed.
99060	Office services	

CPT Codes	Description	Comments
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Not separately reimbursed, use of a specific HCPCS code and/or prior authorization is required for payment consideration.
99075	Medical testimony	Not covered.
99080	Special reports	Not separately reimbursed.
99082	Unusual travel	Not separately reimbursed.
99090	Analysis of data stored in a computer	Not covered.
99143-99145	Moderate sedation	Not separately reimbursed.
99217	Observation Care Discharge Services	
99218 - 99220	Initial observation care	
99221 - 99223	Initial hospital care	
99231 - 99233	Subsequent hospital care	
99234 - 99236	Observation or inpatient care services (including admission and discharge services)	
99238	Hospital discharge day management 30 minutes or less	
99239	Hospital discharge day management more than 30 minutes	
99241 - 99245	Physician consults – outpatient/ER	
99251 - 99255	Inpatient consultations	
99281 – 99285	Emergency Department	Bill for unscheduled episodic emergency medical care provided in the emergency department
99288	Physician direction of emergency medical systems (EMS) emergency care, advanced live support (ALS)	Bill when the physician is located in a hospital emergency or critical care department and is in two-way voice communication with ambulance or rescue personnel outside the hospital
99291, 99292	Critical Care	Bill one unit with code 99291 for the first 30-74 minutes, bill the number of units that represent each additional 30 minutes of critical care time with 99292.
99304 - 99306	Initial nursing facility care	
99307 - 99310	Subsequent nursing facility care	
99315, 99316	Nursing facility discharge services	
99318	Evaluation and Management of patient involving an annual nursing facility assessment.	Do not report 99318 on the same date of service as nursing facility services codes 99304-99316.
99341 - 99350	Physician home services	

CPT Codes	Description	Comments
+99354, +99355	Prolonged services, face-to-face, office or outpatient setting	<ul style="list-style-type: none"> <li>For the first hour use +99354 in conjunction with 99201-99215, 99241-99245, 99304-99350</li> <li>For each additional 30 minutes, use +99355 in conjunction with 99354</li> </ul>
+99356, +99357	Prolonged services, face-to-face, inpatient setting	<ul style="list-style-type: none"> <li>For the first hour, use +99356 in conjunction with 99221-99233, 99251-99255</li> <li>For each additional 30 minutes, use +99357 in conjunction with +99356</li> </ul>
99360	Standby services	Not separately reimbursed
99363, 99364	Anti-coagulation management	
99366	Medical team conference, interdisciplinary team, face-to-face, patient and/or family, 30 minutes or more, with participation by non-physician practitioner	<p>Not separately reimbursed</p> <p>Documentation requirements: must show when conference starts and ends.</p>
99367	Medical team conference, interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by physician	<p>Not separately reimbursed</p> <p>Documentation requirements: must show when conference starts and ends.</p>
99368	Medical team conference, participation by non-physician qualified health care professional	<p>Not separately reimbursed</p> <p>Documentation requirements: must show when conference starts and ends.</p>
99401 - 99404	Preventive medicine, individual counseling	Mutually exclusive if billed with another E&M code.
99406, 99407 (only covered by MassHealth and Senior Plans)	Behavior change interventions, individual (smoking and tobacco cessation)	Not separately reimbursed
99408, 99409	Behavior change interventions, individual (alcohol and/or substance (other than tobacco) abuse structured screening)	<p>Not separately reimbursed</p> <p>Document requirements: must use the standardized 10 item screening questionnaire. www.projectcork.org/clinical_tools</p>
99441 - 99443	Telephone management	FCHP reimburses for telephone calls (99441-99443) with the following diagnosis codes 290.0-290.9, 293.0-302.9, 306.0-316 limited to twice per calendar year. Refer to Team Conference and Telephone Services Payment policy.

CPT Codes	Description	Comments
99466, +99467	Critical Care	Critical care services delivered by a physician, face to face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; first 30-74 minutes of hands-on care during transport. Code 99467 - Bill for each additional 30 minutes. (List separately in addition to code for primary service)
99468, 99471, 99475	Inpatient pediatric critical care	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less. Code 99471- 29 days through 24 months of age. Code 99475- 2 through 5 yrs of age.
99469, 99472, 99476	Subsequent inpatient neonatal critical care.	Subsequent inpatient critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less. Code 99472 – 29 days through 24 months of age. Code 99476 – 2 through 5 yrs of age.
99478 - 99480	Subsequent intensive care per day.	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams). Code 99479 – present body weight of 1500 -2500 grams. Code 99480- present body weight of 2501-5000 grams.

*EDI claim submitter information:*

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed with non-standard codes will reject if billed electronically.

*Paper claim submitter information:*

- Submit claims on a CMS 1500 form for professional services. Claim lines billed with non-standard codes will deny.

## **Place of service**

This policy applies to services furnished by physicians and qualified non-physician practitioners in all areas and settings permitted under applicable laws.

## **Other reference/documentation/policies**

([www.fchp.org/Providers/Medical\\_payment\\_policies.htm](http://www.fchp.org/Providers/Medical_payment_policies.htm))

Nurse Practitioner/Physician Assistant Payment Policy  
Nurse Midwife Payment Policy  
Neonatal and Pediatric Critical Care Services Payment Policy  
Team Conference and Telephone Services Payment Policy

## **Policy history**

Origination date: 09/13/2006  
Previous revision date(s): 10/10/2007, 01/08/2008, 09/01/2008, 01/1/2009  
Connection date & details: 01/01/2009- Updated codes listed in response to 2009 coding changes.

*This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.*