



# Evaluation and Management Payment Policy

## **Policy**

Fallon Community Health Plan will reimburse for medically necessary E&M services. Fallon Community Health Plan 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.

## **Definitions**

This policy applies to Fallon Community Health Plan's payment of professional Evaluation & Management (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 *CRNA Payment Policy* (ADM0026). All claims are subject to auditing edits based on CMS, National Correct Coding Initiative (CCI) and Specialty Society guidelines and FCHP payment policies.

## **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. Medical records must support reported levels of service based on the 1995/1997 documentation guidelines.

#### *New patient definition*

Fallon Community Health Plan 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 90 days from the Remittance Advice Summary (RAS).

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

Fallon Community Health Plan allows one E&M code per day of service per physician group regardless of the places of service. When two E&M services are rendered by the same physician group on the same date of service, the E&M with the highest allowable reimbursement will be processed for payment and any additional E&M codes will be denied.

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 a procedure*

Consistent with CMS guidelines, 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 when a significant, separately identifiable E&M service is above and beyond the usual pre- and post-operative procedure 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 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 not separately reimburse for *established E&M services* when reported with *minor procedures with a 0-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 areas/systems	Moderate	99244=60min 99254=80min
99245/55	4 present factors 10 Review of system 3 past, family, & social	8 body areas/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
- 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 after-hours or on weekends or holidays*

FCHP reimburses in addition for after-hours services (99050) when submitted with basic E&M services for days when the office is normally closed (e.g., holidays, Saturday or Sunday). After-hours does not apply to emergency room services.

FCHP reimburses in addition for services rendered in the evening (99051) when submitted with basic E&M services. Evening begins when office hours end; this is typically 5:00 p.m.

*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

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.
99217-99220	Observation discharge services	
99218-99220	Initial observation care	
99221 - 99239	Inpatient hospital care services	
99241 - 99245	Physician consults – outpatient/ER	
99251 - 99255	Inpatient consultations	
99298 - 99300	Intensive (non-critical) low birth weight services	Bill with appropriate code by weight.
99304 - 99306	Initial nursing facility care	
99307 - 99310	Subsequent nursing facility care	
99315 - 99316	Nursing facility discharge services	
99318	Other nursing facility services	
99341 - 99345	Physician home services	
+99354 - +99355	Prolonged services, face-to-face, office or outpatient setting	<ul style="list-style-type: none"> <li>For the first 60 minutes, 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 60 minutes, 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
99366	Medical team conference, interdisciplinary team, face-to-face, patient and/or family, 30 minutes or more, with participation by non-physician practitioner	Not separately reimbursed  Documentation requirements: must show when conference starts and ends.
99367	Medical team conference, interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by physician	Not separately reimbursed  Documentation requirements: must show when conference starts and ends.
99368	Medical team conference, participation by non-physician qualified health care professional	Not separately reimbursed  Documentation requirements: must show when conference starts and ends.
99363 - 99364	Anti-coagulation management	Not separately reimbursed

99401 - 99404	Preventive medicine, individual counseling	Not separately reimbursed 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)	Not separately reimbursed Document requirements: must use the standardized 10 item screening questionnaire. <a href="http://www.projectcork.org/clinical_tools">www.projectcork.org/clinical_tools</a>
99441 - 99443	Telephone management	Not separately reimbursed. Only used with diagnoses listed within the <i>Team Conferences and Telephone Consult Service</i> payment policy.

*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](#)

## Policy history

Origination date: 09/13/2006  
 Previous revision date(s): 10/10/2007, 01/08/2008  
 Connection date & details: 09/01/2008 Differentiated normal hours from after hours. Defined critically ill. Included bundled CPT procedure codes. Removed deleted codes and updated the comments. Added new codes and updated the add-on codes.

*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.*