



## evaluation and management payment policy

### ***description of procedure/service***

This policy applies to Fallon Community Health Plans payment of professional Evaluation & Management (E&M) services.

### ***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.

### ***benefits application***

- FCHP Direct Care/FCHP Select Care
- FCHP Independent Care
- FCHP Flex Care Direct/Select
- Fallon Senior Plan™
- FCHP MassHealth
- Major Medical
- Bill at Home/Direct Enrollment
- Fallon Preferred Care
- Fallon Senior Preferred Care

### ***coverage and reimbursement criteria***

Coverage is limited to those E&M services legally authorized to perform in accordance with state law. Reimbursement for physician assistants, nurse practitioners and certified 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), Specialty Society guidelines and FCHP payment policies.

### ***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 place 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 preventative 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 requires 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 1 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 weekend or holidays**

FCHP reimburses for after hours services (99050) when submitted with E&M codes 99201 – 99205; 99211 – 99215; or 99241 – 99245.

FCHP reimburses for services rendered on regularly scheduled evening, weekend, or holiday hours when submitted with E&M codes 99201 – 99205; 99211 – 99215.

After hours does not apply to emergency room services.

**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.

**e&m services provided with a procedure**

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**provider billing guidelines**

CPT codes	Description	Comments
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	After hours services provided in the office setting at times other than regular scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturdays or Sunday) in addition to the basic service	Separately reimbursed when submitted with 99201 – 9905; 99211 - 99215
99051	Services provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to the basic service	Separately reimbursed when submitted with 99201 – 9905; 99211 - 99215

99053	Services provided between 10pm and 8am 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 basic 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 provided on an emergency basis out the office which disrupts other scheduled office services, in addition to the basic service	
99070	Materials charges, generic supplies	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 – 99220 99234-99236, 99239, 99251 - 99299	Observation codes  Inpatient E&M services codes	
99281 – 99285	Emergency department codes	Bill for unscheduled episodic emergency medical care.
99288	Physician direction of emergency medical systems (EMS) emergency care, advanced life support (ALS)	Bill when a physician is located in the emergency room directing the performance of the medical procedures through two-way communication with ambulance or rescue personnel outside.

99289, 99290	Pediatric care patient transport	Bill one unit with 99289; bill the number of units that represent each additional 30 minutes of transport time with 99290.
99291, 99292	Critical care	Bill one unit with 99291, bill the number of units that represent each additional 30 minutes of critical care time with 99292.
99293, 99294	Inpatient pediatric critical care	Bill for children age 31 days through 24 months old, per day.
99295, 99296	Inpatient neonatal critical care	Bill critical care services provided to infants less than one month old using the appropriate neonatal intensive care code; bill one unit per day.
99298, 99299	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, 99357	Prolonged services	
99360	Standby services	Not separately reimbursed
99366, 99367, 99368	Medical conferences by a physician with an interdisciplinary team of health professionals to coordinate care of a patient when patient is not present	Not separately reimbursed
99441-99444	Telephone management	Please refer to the <i>Team Conferences and Telephone Consult Service Payment Policy</i>

**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**

*Nurse Practitioner/Physician Assistant Payment Policy:*

[www.fchp.org/providers/manual/pdfs/K Payment/Nurse practitioner physician assist pol.pdf](http://www.fchp.org/providers/manual/pdfs/K%20Payment/Nurse%20practitioner%20physician%20assist%20pol.pdf)

*Certified Nurse Midwife Payment Policy:*

[www.fchp.org/providers/manual/pdfs/K Payment/Nurse midwife payment pol.pdf](http://www.fchp.org/providers/manual/pdfs/K%20Payment/Nurse%20midwife%20payment%20pol.pdf)

*Neonatal/Pediatric Critical Care Payment Policy:*

[www.fchp.org/providers/manual/pdfs/K Payment/Neonatal n pedi critical care servs pymnt pol.pdf](http://www.fchp.org/providers/manual/pdfs/K%20Payment/Neonatal%20n%20pedi%20critical%20care%20servs%20pymnt%20pol.pdf)

## **policy implementation**

Policy number:	ADM0049
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Next review:	01-08-09
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