



Evaluation and Management Payment Policy

Policy

Fallon Community Health Plan (FCHP) will reimburse for medically necessary Evaluation and Management (E&M) services. FCHP recognizes CPT's definitions of services pertaining to E&M services and follows the CMS 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. The presence of documentation that meets the specific CMS 1995/1997 documentation guidelines is not the sole determinant of whether or not a level of E&M service will be reimbursed, however. The reason for the visit must medically support the extent of the HPI, exam and/or discussion time noted.

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
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care
- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®
- NaviCareSM

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 *Nurse Practitioner, Physician Assistant, and Nurse Midwife Payment Policies*. All claims are subject to auditing edits.

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

- For dates of service prior to January 1, 2011, 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).
- For dates of service on or after January 1, 2011, reimbursement will be made for a preventive code with a problem focused code when modifier -25 is applied to the

problem-focused code. Reimbursement for the preventive service will be made at 100% of the contracted rate, and reimbursement for the problem focused service will be made at 50% of the contracted rate. This should only occur when a significant abnormality or pre-existing condition is addressed and additional work is required to perform the key components of a problem focused E&M service. Members have no copayment and/or deductible for routine physical exams. Members will be responsible for a copayment and/or deductible when a problem-focused code with modifier -25 is included on the claim. Therefore, the appropriate use of modifier -25 is critical since it will be transparent to members. Those services coded with modifier -25 will be regularly reviewed for coding accuracy.

- For all other services, FCHP allows one E&M code per day of service per physician group, per specialty regardless of the places of service.

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. The “usual care” for the typical patient is **already covered** by the procedure.
- 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. Those services coded with modifier -25 will be reimbursed and will be regularly reviewed for coding accuracy.

E&M services provided with lab collection and screening services

- For claims processed on or after November 1, 2010, FCHP will **not** reimburse for G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) or G0102 (manual rectal neoplasm screening) when billed on the same date of service as a preventive medicine service (99381-87; 99391-97; S0610; S0612) regardless of location.
- For claims processed on or after November 1, 2010, FCHP will **not** reimburse for Q0091 (screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) when billed on the same date of service as a preventive medicine service (99381-87; 99391-97; S0610; S0612) regardless of location.
- FCHP will **not** reimburse for G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) or G0102 (manual rectal neoplasm screening) when billed on the same date of service as an E&M service (99201-05; 99211-15) regardless of location.
- FCHP will **not** reimburse for Q0091 (screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) when billed on the same date of service as an E&M service (99201-05; 99211-15) 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 preventive medicine service (99381-87; 99391-97).
- FCHP does reimburse 36415 when it is the **sole** service provided.
- FCHP does 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 does 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.

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 procedure 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.

Payments are subject to post-payment audits and retraction of overpayments.

Referral/notification/prior authorization requirements

Summit ElderCare requires prior authorization for all non-emergency outside services. Please contact the referring Summit ElderCare PACE site for assistance.

NaviCareSM requires that all non-emergency services be authorized in advance. Please contact an Enrollee Service Representative at 1-877-700-6996 for assistance.

PCP referrals are required for all specialty visits for most products. For a description of products and services requiring a PCP referral, please refer to the PCP referral and prior authorization grid located in the Managing Patient Care section of the *Provider Manual* under "PCP Referral and Plan Preauthorization Process."

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 CMS 1995/1997 documentation guidelines.

The presence of documentation that meets the specific CMS 1995/1997 documentation guidelines is not the sole determinant of whether or not a level of E&M service will be reimbursed. The reason for the visit must medically support the extent of the HPI, exam and/or discussion time noted. Documentation should support the level of service reported, and the volume of documentation should not be the primary factor upon which a specific level of E&M service is billed.

Payments are subject to post-payment audits and retraction of overpayments.

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)

Critical care services

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

Code	Description	Comments
94760, 94761	Noninvasive ear or pulse oximetry for oxygen saturation	Not reimbursed when billed on the same date of service as an E&M service.
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.	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.	Reimbursed when submitted with E&M services 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	Services provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.	Not reimbursed when submitted with E&M services 99201-99205 and 99211-99215.
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	

Code	Description	Comments
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
99289, 99290	Pediatric care patient transport	Bill one unit with code 99289 for the first 30-74 minutes; bill the number of units that represent each additional 30 minutes of transport time with 99290.
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.
99293, 99294	Inpatient pediatric critical care	Bill critical care services provided for children age 29 days through 24 months old, per day.
99295, 99296	Inpatient neonatal critical care	Bill critical care services provided to neonate 28 days of age or less using the appropriate neonatal intensive care code; bill one unit per day.
99298 - 99300	Intensive (non-critical) low birth weight services	Bill with appropriate code by weight. Bill one unit per day.
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	
+99354 - +99355	Prolonged services, face-to-face, office or outpatient setting	For the first 60 minutes, use +99354 in conjunction with 99201-99215, 99241-99245, 99304-99350 For each additional 30 minutes, use +99355 in conjunction with 99354
+99356 - +99357	Prolonged services, face-to-face, inpatient setting	For the first 60 minutes, use +99356 in conjunction with 99221-99233, 99251-99255 For each additional 30 minutes, use +99357 in conjunction with +99356
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	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.
99401 - 99404	Preventive medicine, individual counseling	Mutually exclusive if billed with another E&M code.
99406 - 99407	Behavior change interventions,	Not separately reimbursed

Code	Description	Comments
(only covered by MassHealth and Senior Plans)	individual (smoking and tobacco cessation)	
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. www.projectcork.org/clinical_tools
99441 - 99443	Telephone management	Fallon Community Health Plan 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 Conferences and Telephone Services 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 be denied.

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.

Policy history

Origination date:	09/13/2006
Previous revision date(s):	10/10/2007, 01/08/2008, 09/01/2008 01/01/2009 Clarified policy for E&M services provided with lab collection and screening services. 11/01/2010- Reorganized content under Reimbursement and Billing/coding guidelines; updated explanation of reimbursement for problem focused with preventive, effective January 1, 2011; updated explanation of reimbursement for services provided with lab collection and screening services to reflect that FCHP will no longer reimburse for G0101 and Q0091 when billed along with a preventive medicine service.
Connection date and details:	November 2010 – Added explanations about denials of codes that are not reimbursed when submitted with E&M services and more specificity about preventive codes with G0101 and Q0091. Removed discussion about billing and documentation requirements for consultation 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.