# Evaluation and Management Payment Policy

## Policy

The Plan will reimburse for medically necessary Evaluation and Management (E&M) services. The Plan recognizes Current Procedural Terminology's (CPT) definitions of services pertaining to E&M services and follows the Centers for Medicare and Medicaid Services documentation guidance inclusive of (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 guidance inclusive of 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.

## Reimbursement

Coverage is limited to those E&M services that 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.

Unless stated otherwise in the provider contract, the Plan does not reimburse consultation codes 99241-99245 and 99251-99255. Providers should bill with the corresponding E&M codes.

New patient definition:
The 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. The Plan 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:

- 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, and services should be submitted on the same claim. Members have no copayment and/or deductible for routine physical exams. Senior Plan 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. Beginning October 1, 2014, the Plan will not calculate a copayment and/or deductible for E&M codes submitted with modifier 25 when billed with annual preventive services for members enrolled in a Commercial plan. Those services coded with modifier 25 will be regularly reviewed for coding accuracy.
- For all other services, the Plan allows one E&M code per day of service per physician group, per specialty, regardless of the places of service.

E&M services submitted with Medicare annual wellness visit:

Problem-focused E&M services will be allowed at 50% of the contracted rate when submitted with Medicare Initial Preventive Physical Examination code G0402 and Annual Wellness Visit codes G0438 or G0439 when modifier 25 is applied to the problem-

focused code. 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 service, and services should be submitted on the same claim. Members will be responsible for a copayment 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.

Medicare Annual Wellness Exam:
The Plan does not reimburse a Medicare Annual Wellness HCPCS code G0438, G0439 or Welcome to Medicare Exam HCPCS code G0402 when billed on the same date of service as an annual physical CPT codes 99381-99397 due to the overlap in services inclusive in these codes.

E&M services provided with an office/outpatient procedure:

- The Plan 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:

- The Plan will not reimburse for G0102 (Prostate cancer screening; digital rectal examination) when billed on the same date of service as a preventive medicine service (99381-87; 99391-97) regardless of location.
- The Plan 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.
- The Plan will not reimburse for G0102 (Prostate cancer screening; digital rectal examination) when billed on the same date of service as an E&M service (99201-05; 99211-15) regardless of location.
- The Plan will reimburse only non-OBGYN PCPs for G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) when billed on the same date of service as an E&M service (99201-05; 99211-15) or preventive medicine service (99381-87; 99391-97) regardless of location.
- The Plan 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.
- The Plan 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 lab CPT codes for blood work.
- The Plan will not reimburse separately for 99000 or 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).
- The Plan does reimburse 36415 when it is the sole service provided.
- The Plan does reimburse 36416 when it is the sole service provided.

E&M services provided within global period:
Based on the CMS global surgical period-

- The Plan does not separately reimburse for any E&M service when reported with major surgical procedures (90-day global surgical period).
- The Plan does not separately reimburse for any E&M service when reported with minor procedures with a 10-day post-op period.

- The Plan does separately reimburse for new patient E&M services and E&M services described in CPT as applying to new or established patients when reported with minor procedures with a 0-day post-op period.
- The Plan does consider reimbursement for services rendered during the global period if the appropriate modifier 24 is appended to the E&M procedure code. Advance Care Planning:
- The plan reimburses advance care planning including the explanation and discussion of advance directives (CPT codes 99497 and 99498) with no member cost-share when provided with an annual preventive visit. Member cost-share will be required when these services are provided outside of the annual preventive visit.

Critical care services:
The Plan 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. This applies only to outpatient services, in-patient services should follow proper billing guidelines for subsequent services by utilizing the appropriate add-on code.

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

Effective May 1, 2016, the following services are no longer reimbursed (due to regulatory requirements these codes are covered for Masshealth and NaviCare):

- 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.
- CPT code 99051 for services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

## Referral/notification/prior authorization requirements

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*.

Fallon Health Weinberg and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

## 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 an 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.

In cases where counseling and/or coordination of care constitute more than 50 percent of the face-to-face or floor time, time will be the key or controlling factor in E&M code selection. Documentation in support of these services should include the following:

- Total duration of face-to-face or floor time.
- The duration of counseling or coordination of care.
- A detailed description of the coordination of care or counseling provided. The documentation needs to provide sufficient information on what was coordinated and what was discussed or advice provided during counseling

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 are 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 test 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, 36591, 36600, 43752, 71010, 71015, 71020, 43753, 92953, 93561, 93562, 94002, 94003, 94004, 94660, 94662, 94760, 94761, 94762, 99090.

Provider billing guidelines:

| Code | Description | Comments |
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| 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 | |
| 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. |
| 99151 - 99153 | Moderate sedation | Not separately reimbursed. |
| 99217 | Observation Care Discharge Services | |
| 99218 - 99220 | Initial observation care | |

| Code | Description | Comments |
|---|---|---|
| 99221 - 99223 | Initial hospital care | |
| 99234 - 99236 | Observation or inpatient care services (including admission and discharge services) | |
| 99239 | Hospital discharge day management more than 30 minutes | |
| 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 | |
| +99354 - +99355 | Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service | For the first 60 minutes, use +99354 in conjunction with 99201-99215, 99304-99350 .<br>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.<br>For each additional 30 minutes, use +99357 in conjunction with +99356 |
| 99360 | Standby services | Not separately reimbursed |
| 93792, 93793 | 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.<br>Documentation requirements: must show when conference starts and ends. |

| Code | Description | Comments |
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| 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 |
| 99406 - 99407 | Behavior change interventions, individual (smoking and tobacco cessation) | The Plan will find counseling and/or risk factor reduction intervention services mutually exclusive to evaluation and management, consultation, and preventive medicine services and will not separately reimburse these services.<br>Document requirements: must use the standardized 10 item screening questionnaire. www.projectcork.org/clinical_tools |
| +99415 - +99416 | Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision | For the first 60 minutes, use 99415 in conjunction with 99201-99205, 99211-99215.<br>For each additional 30 minutes, use 99416 in conjunction with 99415 |
| 99441 - 99443 | Telephone management | FH reimburses for telephone calls (99441-99443) with behavioral health diagnosis codes twice per calendar year. Refer to Team Conferences and Telephone Services Payment Policy. |
| 99451, 99452 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician | |
| 99453-99457 | Remote physiologic monitoring treatment management services | |
| 99466, 99467 | 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. |
| 99468, 99469 | 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 |

| Code | Description | Comments |
|---|---|---|
| | | per day. |
| 99471, 99472 | Inpatient pediatric critical care | Bill critical care services provided for children age 29 days through 24 months old, per day. |
| 99478 - 99480 | Intensive (non-critical) low birth weight services | Bill with appropriate code by weight. Bill one unit per day. |
| 99491 | Chronic care management services | |

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.
01/01/2011 - 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.
11/01/2012 - Added information on reimbursement of problem focused E&M codes with Medicare wellness codes.
05/01/2013 - Updated discussion about preventive medicine services provided with G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) to remove discussion about G0101 denying when billed with preventive medicine services.
09/01/2013 - Added discussion about codes 99241-99245, 99251-99255, and 69210 in reimbursement section.
054/01/2014 - Updated discussion about G0101 reimbursement and removed behavioral health ICD-9 codes from discussion about telephone management.
11/01/2014 - Updated discussion about multiple E&M services on the same day, E&M services with Medicare Initial Preventive Physical Examination code G0402, and moved to Fallon Health template.
09/01/2015 - Annual Review and moved to new Plan template.

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| | 07/01/2016 - Updated to address new codes and replace deleted codes throughout the policy and to indicate that 99050 and 99051 are no longer separately reimbursed.<br>11/01/2016 - Updated the billing/coding guidelines section to clarify coverage of codes 99406-99407.<br>05/01/2017 - Removed deleted codes. |
| Connection date and details: | November 2017 – Updated the billing/coding guidelines section. |
| | April 2018 – Added language to reimbursement section regarding Medicare Wellness exams. |
| | July 2018 – Removed denial of cerumen removal (69209, 69210) when billed with E/M codes, clarified critical care reimbursement language, updated anti-coagulation monitoring codes. |
| | October 2018 – Clarified codes 99050/99051 are covered for Masshealth and Navicare. |
| | January 2019 – Added new 2019 codes. |
| | April 2019 – Clarified policy section regarding CMS documentation requirements. |

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. 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. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*