PROVIDER REIMBURSEMENT GUIDANCE			
Evaluation & Management Services			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
12/7/2017	03/01/2022	03/01/2022	02/01/2022

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

CCA will reimburse for Evaluation and Management (E&M) services.

There are broad categories and subcategories that describe the range of E&M service classifications. The key components appear in the descriptors for most basic E&M codes and many code categories describe increasing levels of complexity.

This reimbursement policy explains when medical records may be requested to ensure that the appropriate level of CPT E&M code is reimbursed based on the health care services provided. The code(s) reported by physicians or other health care professionals should best represent the services provided based on the American Medical Association (AMA) and CMS documentation guidelines.

Effective 1/1/2021 CCA will reimburse all Office or Outpatient services under Evaluation & Management (E&M) following a different set of criteria. History may be updated as medically appropriate and will not have a bearing on code selection. Medical Decision Making (MDM) or total time on the date of the encounter will be the deciding factor.

The elements of Medical Decision Making (MDM) differ from other E&M services as below:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complication and/or morbidity or mortality of patient management Level one new patient office visits will no longer be in effect as of 1/1/2021.

Level one established patient office visits will no longer have a time component. Prolonged services with or without direct patient contact for both new/established office visits are only applicable for level five visits with procedure code 99417 when the service exceeds the total time component of either 99205 or 99215 by 15-minutes. Prolonged services with or without direct patient contact under the code ranges 99354-99357 and 99358-99359 are no longer valid to submit with new/established office visits.

Prolonged clinical staff services with physician or other qualified health care professional supervision are still applicable when billed with 99415/99416.

BILLING AND CODING GUIDELINES:

CCA will reimburse all other medically necessary Evaluation & Management Services (E&M) following 1995/1997 Evaluation and Management guidelines. E&M service codes are a distinct set of CPT codes that are divided into various categories and subcategories based upon where the patient is treated and what level of treatment is required. There are different levels of E&M service and selection of the appropriate level can be determined by seven components:

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of the Presenting Problem
- Time

The key components in selecting a level of E&M service other than outpatient or office visits are:

- History
- Exam
- Medical Decision Making

Medical Decision Making (MDM) differs under the 1995/1997 E&M guidelines from Outpatient/Office visit criteria above and includes:

- The number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality

Documentation must support the level of E&M service billed. Voluminous documentation does not justify a higher level of service than what is warranted. Medical necessity is the overarching criterion for payment.

When time becomes a factor for determining the level of E&M service counseling and/or coordination of care must dominate more than 50% of the encounter with the patient and/or family (face-to-face time in the office setting or floor/unit time in the hospital or nursing facility). Under those circumstances, time will be considered the key or controlling factor to qualify for a particular level of E&M services per CPT guidelines. (Time is not a descriptive component for the Emergency Department levels of E&M services as these are provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time).

Coverage is limited to those E&M services that physicians and qualified non-physician practitioners are legally authorized to perform in accordance with federal and state regulations. CCA recognizes CPT's definition of services that are inclusive of E&M services which include examinations, evaluations, treatments, conferences, with or concerning patients.

REIMBURSEMENT REQUIREMENTS:

New Patient Offices visits will only be reimbursed the first time a patient sees a provider for professional services, and if the provider or another physician of the same specialty and same group practice of has not seen the patient for professional services within the last three years. (99201-99205)

Established Patient Office visits should be reported for those patients who have received professional services from the provider within the last three years. (99211-99215)

E&M services submitted with a Medicare Annual Wellness Visit: Problem focused E&M services can be billed with modifier 25 appended, when a significant abnormality or pre-existing condition is addressed, and additional work is required beyond the scope of the AWV to perform the key components of a problem focused visit.

E&M services provided with removal of impacted cerumen: CCA does not reimburse for removal of impacted cerumen when submitted on the same day as E&M services.

E&M services provided with an office/outpatient procedure: CCA does not allow for the separate reimbursement of E&M services when a substantial diagnostic or therapeutic procedure is performed. The usual care of the patient is already covered by the procedure.

E&M Services provided with lab collection and screening services: CCA will not reimburse G0102, Q0091, when billed on the same day as a preventive medicine service or problem-oriented service (99385-99387), (99395- 99397), (S0610, S0612), (99201-99205), and (99211-99215) regardless of the place of service. CCA will not separately reimburse 36415 and/or 36416 when billed with an office E&M visit, preventive medicine service, or office-based lab CPT codes (i.e., CLIA waived tests). (CCA will reimburse 36415 and 36416 when it is the sole service provided). CCA will not reimburse separately for 99000/99001 when billed with an E&M office visit or preventive medicine service. CCA will reimburse only non-OB/GYN PCP's for G0101 Breast & Pelvic Exam when billed on the same date of service as an E&M service regardless of location.

Multiple E&M Services: When multiple providers within the same specialty using the same federal tax identification number perform E&M services on the same patient, on the same day, only one E&M service will be reimbursed of the highest allowable amount.

Telephone E&M Services: For the duration of the COVID-19 PHE, telephone services will be reimbursed by CCA. Documentation must support the telephone service billed. Per E&M guidelines, if the service ends with a decision to see the patient within 24 hours or by the next available urgent visit appointment telephone services should not be reported. If a telephone call by a physician or other qualified health care professional refers to a service within the previous 7 days (either requested or unsolicited patient follow-up) or within the post-operative period of the previously completed procedure, the service is considered part of the previous E/M service or procedure and should not be reported.

Emergency Department Care: This entails E&M services that are rendered at a hospital for unscheduled episodic care to patients who present for immediate medical attention (the facility must be open 24 hours). Time is not a descriptive component for emergency department E&M levels of service and providers must use CPT codes 99281-99285 for emergency department visits (Place of Service 23) for both established patients and new patients for the emergency department visit. (Note: Providers or other healthcare professionals who are requested to serve as a consult should utilize the appropriate E&M code administered). Providers may experience adjustments to or denials of the office visit or other outpatient E&M code or emergency department E&M code reported if the documentation does not support the E&M level submitted.

Critical Care: In accordance with, but not limited to, the CPT definition of a critical care patient and inclusive of the CPT definition of critical care services – consistent with the total duration of time the physician spends providing his/her full attention to a critically ill or injured patient and the work directly related to the patients care.

Transitional Care Management: CCA will reimburse for Transitional Care Management services so long as the patient has not been readmitted within 30 days of the previous admission. A phone call must be made within two business days of discharge, or at least 2 phone call attempts must be made and documented. The patient must be seen within 7 to 14 calendar days of discharge. Only one TCM can be billed per admission. If the patient is seen exceeding discharge of 7-day period, 99496 will not be reimbursed. If the patient is seen exceeding the 14-day period, 99495 will not be reimbursed. Upon audit review, documentation of the phone call/phone call attempts must be clearly documented in the patients' medical record.

Prolonged Services: CCA will pay for reasonable and necessary face-to-face and non-face-to-face Prolonged E&M services. Documentation must support the medical necessity of the service, time reported, and code(s) billed.

Nursing Facility Services: Nursing Home E&M visits inclusive of services related to the admission and other related services when provided by the same physician (ex: Emergency Room, Doctor's Office).

Physician Home Visit: CCA reimburses physician home visits. In-Office Services Rendered on Sundays and Holidays: CPT code 99050 will only be reimbursed when provided in addition to basic services on Sundays and the following holidays: New Year's Day, Presidents Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Thanksgiving Day, and Christmas Day.

MODIFIERS UTILIZED WITH EVALUATION & MANAGEMENT SERVICES:

Modifier 25: Reporting a Significant Separately Identifiable E&M Service by the Same Physician, or Other Qualified Health Care Professional on the Same Day of the Procedure of Service

Per CPT guidelines, it may be necessary to indicate that on the day a procedure or service was performed, the patient's condition required a significant, separately, identifiable service above and beyond the other service provided or beyond the usual pre-operative and post-operative care associated with the procedure that was performed.

Modifier 25 should not be appended to E&M Add-on codes or to any procedure/service other than Evaluation & Management codes.

Modifier 25 should not be used when E&M services are billed in conjunction with cerumen removal (69209, 69210)

Modifier 24: Reporting an Unrelated E&M Service During a Global Period

CCA will pay for an E&M service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) if it was provided during the post-operative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with CPT modifier "-24" and accompanied by documentation that supports that the service is not related to the post-operative care of the procedure.

Based on the CMS Global Surgical Period CCA **does not** separately reimburse for:

- Any E&M service when reported with major surgical procedures (90-day global surgical period
- Any E&M service when reported with minor procedures (10-day global surgical period)

CCA does separately reimburse for New Patient E&M services (99201-99205) when reported with procedures with a 0-day post-operative period.

Modifier 27: Reporting Multiple Outpatient Hospital E&M Encounters on the Same Date

Utilization of hospital resources related to separate and distinct E&M encounters performed in multiple outpatient hospital settings on the same date of service can be reported by appending modifier 27 (e.g., Emergency Room, Hospital Clinic).

This modifier is not to be used for multiple E&M services performed by the same physician.

Modifier 57: Reporting a Decision for Surgery

An E&M service that resulted in the initial decision to perform the surgery may be identified by appending modifier 57 to the E&M service.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

American Medical Association (AMA) Current Procedural Terminology (CPT®)

Commonwealth Care Alliance

Medicare Benefit Policy Manual 100-04 Ch 15 30.6.6

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

POLICY TIMELINE DETAILS

1. Effective 1/01/2018
2. Revised format, E&M, Modifier 24, 25, 27, 57 usage guidelines 8/2019
3. Reviewed 2020 annual update, no changes 4
4. January 2021 E&M guidelines updated
5. Revised November 2021, added MAPD