Payment Policy:	**Evaluation & Management Services (Modifier 24, 25, 27, 57)**	
Original Date Approved: 12/7/2017	**Effective Date** 1/1/2018	**Date Revised:** 8/16/2019
Scope: Commonwealth Care Alliance (CCA) Product Lines: ☒ Senior Care Options ☒ One Care		

PAYMENT POLICY SUMMARY:

CCA will reimburse for 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 are:

- History
- Exam
- Medical Decision Making.

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. **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*.**

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.

BILLING AND CODING GUIDELINES:

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 are allowed to 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 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.

Telephone E&M Services: CCA reimburses two telephone E&M services (5-10 minutes of medical discussion) per calendar year for members with associated behavioral health diagnoses for the purpose of clinical management.

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)

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 Years 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 patients 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.

RELATED SERVICE POLICIES:

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 and 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:

Medicare Benefit Policy Manual 100-04 Ch 15 30.6.6

AMA CPT 2019©

Commonwealth Care Alliance

POLICY TIMELINE DETAILS

1. December 2017 drafted
2. January 2018 Effective
3. Revised format, E&M, Modifier 24, 25, 27, 57 usage guidelines 8/2019