BlueCross BlueShield Minnesota

REIMBURSEMENT POLICY
Evaluation and Management Services

Active

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Description

This policy addresses Blue Cross and Blue Shield of Minnesota's (Blue Cross) coverage and reimbursement for illness-related and preventive evaluation and management services (E/M).

Definitions

E/M services refer to visits and consultations furnished by physicians, or other qualified health care professionals.

The E/M section of the CPT manual is divided into broad categories such as office visits, hospital visits and consultations.

Each section has basic guides or requirements for selection, such as new versus established patient, or office- versus hospital-based services.

Policy Statement

E/M Basics

Blue Cross would like to clarify and expand on our requirements for E/M services. The following guides cover how Blue Cross treats preventive and illness E/M services and what Blue Cross expects for documentation if the claim is appealed.

Illness E/M and Preventive on Same Date

Preventive E/M services reflect an age and gender appropriate history/exam. The types of services will vary and include counseling or anticipatory guidance based on age and/or sex.

For example, an E/M preventive service for a 28-year-old adult female may include a pelvic examination including obtaining a Pap smear, breast examination, and counseling regarding diet and exercise, substance abuse, sexual activity and birth control.

What is included in each?

The following table distinguishes E/M illness/problem-oriented codes (99202-99205, 99211-99215, 99241-99245, 99251-99255) from annual preventive exam codes (99381-99387, 99391-99397).

Illness/Problem-oriented	Preventive
1. Management of 3 Chronic Conditions, or 2. Chief Complaint (CC)/Problem oriented 3. History of Present Illness (HPI)/Status of conditions 4. Review of Systems (ROS) as applicable 5. Past, Family and Social History (PFSH) as applicable 6. Appropriate Exam based on presenting problem 7. Decision Making/Risk/Treatment 8. Diagnosis-condition, signs, or symptoms 9. Bill Level based on work performed/risk	1. Patient asymptomatic 2. No CC or PI 3. Comprehensive ROS 4. Comp or interval PFSH 5. Comprehensive Exam 6. Risk Reduction 7. Counseling 8. Diagnosis – routine or preventive 9. Select Code based on age and new or established

Immunizations and ancillary studies involving lab, X-rays or other procedures/services are not included in either type of service or should be reported separately using the appropriate diagnosis.

Significant and separately identifiable
If a problem or abnormality requires additional work and
the performance of the key components of a problem-oriented E/M service, modifier -25 should be appended to the Office/Outpatient code reported. Appending modifier -25 indicates that a significant, separately identifiable E/M (above and beyond the preventive medicine E/M service) was provided by the same physician on the same day as the preventive medicine service.

What is significant?
An issue is considered a “significant issue” when a new or different abnormality/medical problem or a change or exacerbation of a previous condition is revealed in the process of examining the patient and the physician determines it is significant enough to require additional work to perform the components of the appropriate E/M.

What is identifiable?
Separate documentation or records are not required, but it needs to be clear to an auditor or someone outside of the clinic what documentation relates to the preventive E/M and what to the illness E/M. The chief complaint for the illness E/M should be clearly identifiable in the record. The illness complaint or abnormal finding should not be intermixed within the body of the physical exam documentation.

Regardless of what guide used, any part of the preventive exam cannot be used again to support the billing of the illness E/M, such as patient history or review of systems.

What does not count for extra work for support of the illness E/M?
- Prescription refills and/or samples for chronic stable conditions
- Rule out X-rays
- Rule out blood work
- Referral to another physician or qualified healthcare professional

- Decision to "observe" (is not considered treatment)
- Chronic or past diagnosis(es) that are not treated (for example, change in meds)
- Results of test(s)

If treated at the visit, an uncontrolled diagnosis must be supported in the documentation to be considered.

Why does Blue Cross deny level 4 or 5 illness E/Ms with a preventive E/M?
Codes **99214** and **99215** involve a moderate or high complexity review and the focus of the visit may no longer be preventive in nature.

Denials may be appealed. All supporting documentation must be included with the appeal request or will be denied for lack of documentation. For example, if the doctor states "vitals as noted" or "physical form filled out," the documentation must state where it is noted in the chart. This should be included with the appeal.

Why doesn't Blue Cross allow codes 99202-99205 with a preventive E/M?
New patient illness E/M codes will not be allowed with preventive E/M codes, including the new patient preventive E/M codes **99381-99387**. The additional work for an initial service will be met in the billing of the initial preventive E/M. Any additional E/M service during the same would be considered established.

Although the CPT manual may not clearly state that a new illness related E/M should not be billed with a new patient preventive exam, Blue Cross will not allow two new patient services at the same visit based on the rationale stated above. Because the patient already received professional services as part of the preventive E/M, he or she no longer meets the "new patient" criteria. A new patient is one who has not received any professional services from the provider or another provider of the same specialty or subspecialty who belongs to the same group practice (same tax ID) within the past three years.

When may it be appropriate to bill an office visit on the same day as a procedure?
If the patient comes in only for the procedure – only bill for the procedure.
If the patient comes in knowing they are going to have the procedure done, but they also have a new complaint, then the practitioner may code for the E/M appended with the -25 modifier and the procedure.
If the patient comes in with a new complaint, and during that time the practitioner makes the decision that a particular procedure needs to be done at that visit, then the practitioner may code for the procedure and the E/M appended with the -25 modifier.

Office or Other Outpatient and Initial Inpatient Consultations
CMS does not allow submission of inpatient and outpatient consultation codes for Medicare claims. This coding and submission will be followed only for our Medicare business. There is **no** change for all other lines of business. Blue Cross accepts all valid HIPAA medical codes. The consultation codes **99241-99245** and **99251-99255** are still valid CPT codes and as such will be accepted. We expect that the documentation will support any code submitted.

Consultation codes **99241-99245** and **99251-99255** include a physician's or qualified healthcare professional services requested by another physician or other appropriate source, for further evaluation or management of the patient. They are designated according to place of service and apply to new or established patients.

The consultant must document the consult request and the reason for the consult in the patient record and must also appear in the requesting practitioner's plan of care.

The consult request is typically in writing, or documented in the EMR, but it may be verbal so long as both the requestor and the consultant document the conversation in the patient's medical record. The consultant must provide a written report to the requesting practitioner, this may be documented in the shared EMR. A reference to "cc" with appropriate documentation in the medical record is enough to justify billing a consultation.

A consultation may include the diagnostic tests needed to provide an opinion or advice. If the physician or qualified healthcare professional consultant introduces further therapeutic services, documentation must show that the consultant recommended a course of action at the request of the attending physician or qualified healthcare professional. Any subsequent services and continuing care rendered by the consultant cease to be a consultation and become established patient care services.

Initial or subsequent services rendered by a consultant may make an initial consultation invalid if records show that patient care was immediately assumed as in a referral.

A referral is the transfer of total or specific care of a patient from one physician or qualified healthcare professional to another and does not constitute a consultation. Initial evaluation and subsequent service for a referral are designated as level-of-service office visits.

Second or confirmatory consults are coded as the appropriate E/M for the setting and type of service.

New and Established Patients

A new patient is one who has not received any professional services from the provider or another provider of the same specialty or subspecialty who belongs to the same group practice (same tax ID) within the past three years. A new patient visit, when billed by a non-physician practitioner will be denied if a previous face-to face service was already billed by the same group practice (same tax ID) within the last three years, if the primary diagnosis on the claim matches any diagnosis on the previous face-to-face service.

An established patient is one who has received services from the provider or another provider of the same specialty or subspecialty who belongs to the same group practice (same tax id), within the past three years.

Preventive Medicine

Routine examinations for adults and children should be submitted with CPT codes **99381-99387 or 99391-99397**, according to the age of the patient.

The routine nature of the examination should also be indicated by the ICD code submitted.

Illness and injury-related visits should be submitted with the office or outpatient E/M codes **99202- 99205 and 99211-99215** with the appropriate ICD code indicating the illness, injury, symptom or complaint.

The ICD code indicates the purpose of performing the examination. Examinations performed in the absence of complaints should be billed as preventive medicine to be compatible with the

ICD code submitted.

Providers can bill both an E/M code and a preventive medicine code when a patient goes in for a routine exam and an illness/problem that is significant enough to require additional work is found or addressed. In this case, providers may bill **99381-99387 or 99391-99397** with a routine diagnosis code and an illness E/M code **99211-99213** with a **-25** modifier and an illness diagnosis code.

The **-25** modifier indicates a significant, separately identifiable E/M service by the same physician on the day of a procedure or service. The appropriate level of E/M should be submitted.

Generally, a level 4 or 5 illness E/M (**99214, 99215**) is not allowed in conjunction with a preventive E/M. The reason for this is that a level 4 or 5 would require significant additional work, so it would seldom be appropriate to bill both. Denials can be appealed but would require documentation to support both E/M services. Also, new patient illness E/M codes (99202-99205) will not be allowed with preventive E/M codes.

The documentation for the E/M must not be combined into or be part of the documentation for the preventive physical. The problem(s) addressed must be significant enough to require additional work. All key components for the level E/M reported must be met and supported. Beginning in 2021, for codes 99202-99205 and 99211-99215, history and exam will no longer be considered key components. A medically appropriate history and exam will be required instead.

Developmental testing, **96110**, is considered part of an age-appropriate preventive medicine E/M and as such, will deny if billed in addition to the preventive visit.

Multiple E/Ms Same Day

Typically, only one E/M should be reported per date of service.

When multiple E/M services are reported on the same date of service, only the most clinically intense E/M service will be recommended for reimbursement.

This auditing logic is consistent with CMS guidelines from the Medicare Claims Processing Manual, Chapter 12, section 30.6.5 that states, "If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty or subspecialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level."

Only one E/M will be allowed per day per provider or provider group. Additional E/Ms will deny with the message:

'This procedure can only be performed a specified number of times on a single date of service and has already been processed on this or another claim.'

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Documentation Submission

Blue Cross requires reasonable documentation that services are consistent with the health plan coverage provided, that services are medically necessary, and appropriate diagnostic and/or therapeutic services are provided and/or the services furnished have been accurately reported. Documentation does not need to be submitted with every claim; however, it must be readily available on request or submitted, as appropriate, with an appeal or replacement claim.

It is important to note that even if all requirements of a code are documented, if medical necessity is not established, the service may be denied.

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For E/M services, the nature and amount of physician or qualified health care professional work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible. Vitals, forms, and anything pertaining to the visit needs to be complete and contained in the record.

2. The documentation of each patient encounter should include:
   - Reason for the encounter and medically appropriate history, physical examination findings and prior diagnostic test results;
   - Assessment, clinical impression or diagnosis;
   - Plan for care; and
   - Date and legible identity of the observer. On review, documentation not signed by the physician/practitioner performing the service will subject the entire visit to denial.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

7. The CPT and ICD codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record. Include ALL diagnoses addressed during the encounter. Diagnoses MUST be coded to the highest degree of specificity for accurate risk adjusted quality review.

Additional reminders:

- Use of the term IBID (same as above) and/or the use of quotation marks to replace or repeat previously documented information is not acceptable. All information must be in date sequence order.
- Uses of question marks (?) or underline (_) are no considered to be part of a complete medical record. Dictation transcription should be reviewed by the medical practitioner and updated prior to sign-off to ensure complete medical records are maintained.

- Each page in the medical record must contain the patient's name and/or identification number.
- All encounters/entries must be dated.
- Services not clearly documented are not covered by Blue Cross and will be denied as participating provider liability. Failing to submit requested medical records may result in claims being denied or payment being recouped from a provider. Patients are not financially liable for services that are denied for inadequate documentation.

What information would constitute as a plan of care?
For a physician's or qualified healthcare professionals note to qualify as a plan of care, it would need to contain at least:

- the patient's diagnosis,
- long term goals, and
- the type, amount, duration and frequency of services.

It must be established before treatment has begun and may be adjusted by the appropriate practitioner.

Time Documentation
The total time spent on the date of the encounter, with either the patient or family should be noted for levels of service 99202-99205 and 99211-99215. This is particularly important in a situation where medical decision making does not support the level of service on the claim.

In general, to bill an E/M code, the physician must complete at least 2 out of 3 key components applicable to the level of service provided. However, for office/ outpatient codes 99202-99205 and 99211-99215, the physician may document time spent with the patient in conjunction with documenting the medical decision-making involved.

Medical decision making of a service is the overarching criterion for payment in addition to the individual requirements of CPT codes 99202-99205, 99211-99215 (medically appropriate history and physical examination). It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.

Documentation should be in enough detail to support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

You must appropriately and sufficiently document in the medical record that you (the physician or qualified NPP) personally furnished direct face-to-face time with the patient or with a family member. Be sure to include the start and end times of the visit.

In the office and other outpatient setting, total time refers to the time with the physician only. Counseling by other staff is not considered to be part of the total physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient.

Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

1995 and 1997 E/M Guidelines
Blue Cross will require either the Centers for Medicare and Medicaid (CMS) 1995 or 1997 E/M documentation guidelines for all E/M services except office/outpatient codes 99202-99205 and 99211-99215.

Refer to the following publications for the official documentation guidelines:

- 1995 Documentation Guidelines for Evaluation and Management Services, available at
- **www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf on the CMS website;**
- 1997 Documentation Guidelines for Evaluation and Management Services, available at **www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf on the CMS website.**

What are the differences between the 1995 and 1997 Medicare E/M guidelines when it pertains to the different exam levels?
The 1995 Guidelines define the different exam levels as follows:

- **Problem Focused** -- a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- **Detailed** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Comprehensive** -- a general multi-system examination or complete examination of a single organ system.

The 1997 Guidelines contain the following definitions:

- **Problem Focused Examination** -- should include performance and documentation of one to five elements identified by a bullet (o) in one or more organ system(s) or body area(s).
- **Expanded Problem Focused Examination** -- should include performance and documentation of at least six elements identified by a bullet (o) in one or more organ system(s) or body area(s).
- **Detailed Examination** -- should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (o) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (o) in two or more organ systems or body areas.
- **Comprehensive Examination** -- should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet (o) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross fee schedule amount and any coding edits.

The following applies to all claim submissions.

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All coding and reimbursement are subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	25						
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	96110	99202	99203	99204	99205	99211	99212
	99213	99214	99215	99241	99242	99243	99244
	99245	99251	99252	99253	99254	99255	99381
	99382	99383	99384	99385	99386	99387	99391
	99392	99393	99394	99395	99396	99397	99483
	99484	99499					
Revenue Codes:	N/A						
Deleted Codes:	99201						

Policy History

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