# 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.

Beginning on January 1, 2021, physicians and qualified healthcare providers will report office or other outpatient services (99202, 99203, 99204, 99205, 99121, 99213, 99214, 99215) based upon either the level of medical decision-making (MDM) or the total time spent on the day of the visit. See **Instructions for selecting a level of office or other outpatient service** under **Billing/coding guidelines** below. Providers will no longer use history and exam to select the office/outpatient E&M visit level. Instead, an office/outpatient E&M visit includes a medically appropriate history and exam, when performed. Providers should perform history and exam to the extent clinically appropriate and medically necessary.

Medical records may be requested for review to ensure appropriate documentation of services rendered and accuracy of coding.

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 other qualified healthcare providers are legally authorized to perform in accordance with state law.

Reimbursement for physician assistants, nurse practitioners, and certified nurse midwives will be made according to the *Nurse Practitioner*, *Physician Assistant*, and *Certified 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.

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

The Plan follows the American Medical Association's definition of a new patient (see **Determination of Patient Status as New or Established Patient** under **Billing/coding guidelines** below). 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. 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. 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) or E&M service (99202-05; 99211-15) 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 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 (99202-05; 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 (99202-05; 99211-15) regardless of location.
- The Plan will not reimburse separately for 36415 (collection of venous blood by venipuncture) when billed along with an E&M office visit (99202-05; 99211-15) or preventative medicine service (99381-87; 99391-97), T1015 (Clinical Visit) or lab CPT codes for blood work.
- The Plan will not reimburse separately for 99000 or 99001 (lab specimen handling services).
- The Plan does reimburse 36415 when it is the sole service provided.
- The Plan will not reimburse EKG services separately when billed on the same date as an E/M service.

**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 may 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 may consider reimbursement for an unrelated E&M service rendered by the same physician* during the global period if the appropriate modifier 24 is appended to the E&M procedure code.

* Same physician - Physicians in the same group practice who are in the same specialty must bill as though they were a single physician.

**Advance Care Planning**

- The plan reimburses advance care planning including the explanation and discussion of advance directives (CPT codes 99497 and 99498).

**Concierge medicine**

Concierge medicine, also known as concierge care is membership-based healthcare in which the patient pays a monthly, quarterly or annual fee in exchange for the service of a healthcare provider. The Plan does not reimburse concierge medicine membership fees.

**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.

**Miscellaneous services**

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.

**Suture removal by a physician other than the physician who originally closed the wound**

Effective March 1, 2022, HCPCS code S0630 (removal of sutures; by a physician other than the physician who originally closed the wound) is no longer reimbursed. Claims for S0630 will deny vendor liable.

When an established patient visits a physician (or other qualified health care professional) who did not place sutures for the sole purpose of removing them, the physician should report the E&M code that most closely describes the visit with ICD-10-CM code Z48.02.

**Tobacco cessation counseling services for MassHealth ACO members**

The Plan covers a total of 16 tobacco cessation counseling sessions per 12 months for MassHealth ACO members. These sessions may be any combination of group and individual counseling. Tobacco cessation counseling services must be reported with CPT code 99407 (Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes).Tobacco cessation counseling services do not require prior authorization.

- Individual counseling consists of face-to-face tobacco-cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco cessation services. Individual counseling sessions must be at least 30 minutes, except for intake sessions, which must be at least 45 minutes. Intake sessions are limited to two per member per 12-months.
- Group tobacco treatment counseling consists of a scheduled counseling session with a minimum of three and a maximum of 12 members, and a duration of at least 60-90 minutes.

Qualified Providers

a) Physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists, and physician assistants may provide tobacco cessation counseling services without additional experience or training in tobacco cessation counseling services.
b) All other providers of tobacco cessation counseling services must complete a course of training in tobacco cessation counseling by a degree-granting institution of higher education with a minimum of eight hours of instruction.

A physician must supervise all registered nurses and other individuals who qualify as providers of tobacco cessation counseling services for whom the physician will submit claims.

The following modifiers are used by physicians and other qualified providers in combination with CPT Code 99407 to report tobacco cessation counseling. CPT Code 99407 may also be billed without a modifier to report an individual smoking and tobacco-use cessation counseling visit of at least 30 minutes.

| Modifier | Modifier Description |
|---|---|
| HQ | Group counseling, at least 60–90 minutes in duration, provided by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, psychiatric clinical nurse specialist or certified nurse midwife |
| TD | Individual counseling provided by a registered nurse (RN) under the supervision of a physician. |
| TF | Individual counseling, intensive (intake/assessment counseling, at least 45 minutes in duration) provided by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, psychiatric clinical nurse specialist or certified nurse midwife |
| U1 | Individual counseling services provided by a tobacco-cessation counselor under the supervision of a physician |
| U2 | Individual counseling; intensive (intake/assessment counseling, at least 45 minutes in duration), provided by a registered nurse or a tobacco-cessation counselor, under the supervision of a physician |
| U3 | Group counseling, at least 60–90 minutes in duration, provided by a registered nurse, or a tobacco-cessation counselor, under the supervision of a physician |

For applicable modifiers and corresponding modifier descriptions for tobacco cessation counseling provided by Community Health Centers please refer the **MassHealth Community Health Center Manual Subchapter 6, Section 611** on the MassHealth website.

## Referral/notification/prior authorization requirements

PCP referrals are required for most specialty visits. For a list of services requiring a PCP referral, please refer to Member Handbook/Evidence of Coverage.

Fallon Health Weinberg and Navicare models of care are based on member 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 Summit Eldercare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

## Billing/coding guidelines

### Instructions for selecting a level of office or other outpatient services (99202, 99203, 99204, 99205, 99121, 99213, 99214, 99215)

**Determination of Patient Status as New or Established Patient**
Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

In the instance where a physician/qualified health care professional is on call for or covering for another physician/ qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

**Selecting the appropriate level of office or outpatient service (99202, 99203, 99204, 99205, 99121, 99213, 99214, 99215)**

Effective January 1, 2021, select the appropriate level of office or other outpatient service based on the following:

1. The level of the MDM as defined for each service, or
2. The total time for the office or other outpatient services services performed on the date of the encounter.

History and/or examination are required only as medically appropriate for all levels of both new and established patient codes.

**Using time to select an office or other outpatient service code**

Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate level for office or outpatient services (99202, 99203, 99204, 99205, 99121, 99213, 99214, 99215). For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by the clinical staff).

The intervals of total time corresponding to CPT codes 99202-99215 are defined in the table below:

| Code | Reporting Time Effective in 2021 |
|---|---|
| 99202 | 15-29 minutes total time on day of encounter |
| 99203 | 30-44 minutes total time on day of encounter |
| 99204 | 45-59 minutes total time on day of encounter |
| 99205 | 60-74 minutes total time on day of encounter |
| 99211 | Concept does not apply |
| 99212 | 10-19 minutes total time on day of encounter |
| 99213 | 20-29 minutes total time on day of encounter |
| 99214 | 30-39 minutes total time on day of encounter |
| 99215 | 40-54 minutes total time on day of encounter |

Physician and other qualified health care professional time includes the following activities, when performed:

- Preparing to see the patient (e.g, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examiniation and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, procedures
- Referring and communicating with other health care professionals
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination

Do not count time spent on the following:

- The performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of the specific patient

Shared or split visits - A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

**Selecting an office or outpatient service code based on medical decision making (MDM)**
MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM in the officr or other outpatient services is defined by three elements:
Element 1: The number and complexity of problems that are addressed during the encounter.
Element 2: The amount and/or complexity of data to be reviewed and analyzed.
Element 3: The risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnositic procedure(s), treatment(s).

Beginning in 2021, for both new and established patients, to qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Four types of MDM are recognized: straight-forward, low, moderate and high. The concept of level of MDM does not apply to 99211.

**Definitions for MDM**
The following terms are used in medical decision making. It is important to understand these definitions in order to ensure you are selecting the appropriate CPT code:

- Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
- Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (CPT 99211).
- Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.
- Stable, chronic illness: A problem with an expected duration of at least a year or until the death of the patient. Examples may include wellcontrolled hypertension, noninsulin-dependent diabetes, cataract, or benign prostatic hyperplasia.

- Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. Examples may include cystitis, allergic rhinitis, or a simple sprain.
- Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.
- Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

- Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. Systemic symptoms may not be general, but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.
- Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

**Element 1: Problem(s) addressed**

| CPT Code | Number and Complexity of Problems Addressed |
|---|---|
| 99211 | N/A |
| 99202<br>99212 | **Minimal**<br>1 self-limited or minor problem |
| 99203<br>99213 | **Low**<br>2 or more self-limited or minor problems; or<br>1 stable, chronic illness; or<br>1 acute, uncomplicated illness or injury |
| 99204<br>99214 | **Moderate**<br>1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or<br>2 or more stable, chronic illnesses; or<br>1 undiagnosed new problem with uncertain prognosis; or<br>1 acute illness with systemic symptoms; or<br>1 acute complicated injury |
| 99205<br>99215 | **High**<br>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or<br>1 acute or chronic illness or injury that poses a threat to life or bodily function |

**Element 2: Data reviewed and analyzed**

* Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.

| CPT Code | Amount and/or Complexity of Data to be Reviewed and Analyzed |
|---|---|
| 99211 | N/A |
| 99202<br>99212 | **Minimal or none** |
| 99203<br>99213 | **Limited**<br>(Must meet the requirements of at least 1 out of 2 categories)<br>**Category 1: Tests and documents**<br>Any combination of 2 from the following:<br>• Review of prior external note(s) from each unique source*;<br>• Review of the result(s) of each unique test*;<br>• Ordering of each unique test*<br>or<br>**Category 2: Assessment requiring an independent historian(s)**<br>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high) |
| 99204<br>99214 | **Moderate**<br>(Must meet the requirements of at least 1 out of 3 categories)<br>**Category 1: Tests, documents, or independent historian(s)**<br>Any combination of 3 from the following:<br>• Review of prior external note(s) from each unique source*;<br>• Review of the result(s) of each unique test*;<br>• Ordering of each unique test*; |

| | |
|---|---|
| | • Assessment requiring an independent historian(s)<br>or<br>**Category 2: Independent interpretation of tests**<br>Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)<br>or<br>**Category 3: Discussion of management or test interpretation**<br>Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) |
| 99205<br>99215 | **Extensive**<br>(Must meet the requirements of at least 2 out of 3 categories)<br>**Category 1: Tests, documents, or independent historian(s)**<br>Any combination of 3 from the following:<br>• Review of prior external note(s) from each unique source*;<br>• Review of the result(s) of each unique test*;<br>• Ordering of each unique test*;<br>• Assessment requiring an independent historian(s)<br>or<br>**Category 2: Independent interpretation of tests**<br>Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)<br>or<br>**Category 3: Discussion of management or test interpretation**<br>Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) |

**Element 3: Risk**

* Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.

| CPT Code | Risk of Complications and/or Morbidity or Mortality of Patient Management |
|---|---|
| 99211 | N/A |
| 99202<br>99212 | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| 99203<br>99213 | **Low risk of morbidity from additional diagnostic testing or treatment** |
| 99204<br>99214 | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |
| 99205<br>99215 | **High risk of morbidity from additional diagnostic testing or treatment**<br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors |

| | |
|---|---|
| | • Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

**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.
- 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 |
|---|---|---|
| 94760, 94761 | Noninvasive ear or pulse oximetry for oxygen | Not reimbursed when billed on the same date of service as an E&M |

| Code | Description | Comments |
|---|---|---|
| | saturation | 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 covered |
| 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 99202-99205 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. |
| 99217 | Observation Care Discharge Services | |
| 99218 - 99220 | Initial observation care | |
| 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 |

| Code | Description | Comments |
|---|---|---|
| | | 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 99202-99215, 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 | |
| 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. |
| 99367 | Medical team conference, interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by physician | Not separately reimbursed. |
| 99368 | Medical team conference, participation by non-physician qualified health care professional | Not separately reimbursed. |
| 99406 - 99407 | Behavior change interventions, individual (smoking and tobacco cessation) | Please see Counseling/Risk Factor Reduction for guidance on Payment with E/M |
| +99415 - +99416 | Prolonged clinical staff | For the first 60 minutes, use |

| Code | Description | Comments |
|---|---|---|
| | 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 | 99415 in conjunction with 99202-99205, 99211-99215.<br>For each additional 30 minutes, use 99416 in conjunction with 99415 |
| 99417 | Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services) | Code 99417 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the minimum time required to report the highest-level service (i.e., 99205 or 99215) has been exceeded by 15 minutes.<br><br>Covered for MassHealth members effective for dates of service on or after November 1, 2021 per MassHealth Transmittal Letter PHY-162.<br><br>CPT 99417 is not covered for Medicare or commercial plan members. |
| 99441 - 99443 | Telephone management | |
| 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 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 | |

| Code | Description | Comments |
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| G2211 | Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established | Section 113 of the Consolidated Appropriations Act delays payment for this code under the Medicare Physician Fee Schedule until January 1, 2024.<br><br>Effective 1/1/2021, HCPCS code G2211 is a bundled service (i.e., not separately reimbursed). |
| G2212[1] | Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact | Covered for Medicare Advantage, NaviCare and PACE only<br><br>Code G2212 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the minimum time required to report the highest-level service (i.e., 99205 or 99215) has been exceeded by 15 minutes.<br><br>Documentation about the duration and content of the medically necessary evaluation and management service and prolonged services billed is required in the medical record. The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions.<br><br>The start and end times of the visit should be documented in the medical record along with the date |

[1] Effective January 1, 2021, the Centers for Medicare & Medicaid Services (CMS) finalized HCPCS code G2212 for prolonged office/outpatient evaluation and management (E&M) visits. HCPCS code G2212 is to be used when billing prolonged office/outpatient E & M visits for Medicare lines of business (Medicare Advantage, NaviCare and PACE), instead of CPT codes 99358, 99359 or 99417, for dates of service on and after January 1, 2021.

| Code | Description | Comments |
|---|---|---|
| | | of service. |

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.
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.
11/01/2016 - Updated the billing/coding guidelines section to clarify coverage of codes 99406-99407.

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| | 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. |
| | July 2019 – Removed language related to member cost-share, add code T1015 to non-reimbursed with codes (36415/36416), removed termed code. |
| | July 2020 – Updated Reimbursement and Billing Coding Guidelines section. |
| | January 2022 – Updated instructions for selecting a level of office or other outpatient service; added instructions for billing for suture removal by a physician other than the physician who originally closed the wound; added instructions for billing for tobacco cessation counseling for MassHealth ACO members. |

*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.*