Minuteman Health

Payment Policy
Evaluation and Management

PURPOSE

The purpose of this payment policy is to describe Minuteman Health Inc.'s (MHI) reimburses for Evaluation and Management Services.

APPLICABLE PLANS

- ✓ MHI MA Plans
- ✓ MHI NH Plans

DEFINITIONS

Evaluation and Management Services refer to visits and consultations furnished by physicians and the following qualified non-physician practitioners (NPPs):

- Nurse practitioners;
- Clinical nurse specialists;
- Certified nurse midwives; and
- Physician assistants

The services must be furnished within the scope of practice in the State in which the physician or NPP practices.

REQUIREMENTS

MHI reimburses medically necessary Evaluation and Management (E&M) codes following the 1995/1997 CMS documentation guidelines. Documentation in the medical record must clearly support the procedures, services and supplies coded on the claim. If something is not documented in the medical record, then the service or procedure is not considered to have been performed and therefore is not subject to reimbursement. However, documentation alone does not support the level of service reported. The presenting problem of the patient must justify the medical necessity for the extent of services provided and documented.

A. Multiple E&M Services

Payment is only made for one E&M code per practice (Tax ID), per specialty type, per date of service

B. New Patient

MHI 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, within the past three years. MHI will deny subsequent new patient visits. For the purposes of this policy, same specialty

physician is defined as a physician and/or other health care professional of the same group and same specialty.

- In the instance where a physician is covering for another physician, the patient's encounter with the covering physician should be coded as if it was being billed by the physician who was not available. When billing, the covering physician cannot bill the patient encounter as a new patient merely because the patient has not previously received services from them.
- No distinction is made between new and established patients in the emergency department for the purpose of determining new patients.

C. Consultation Codes

MHI does not recognize consultation codes. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed.

- Office or Outpatient: In the office or other outpatient setting where an evaluation is performed, physicians and qualified non-physician practitioners shall use the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician. All physicians and qualified NPPs shall follow the E/M documentation guidelines for all E/M services.
- Inpatient: In the hospital setting and the nursing facility setting all physicians (and qualified NPPs where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306). The principal physician of record is identified in Medicare as the physician who oversees the patient' care from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier "AI", Principal Physician of Record, in addition to the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits or subsequent nursing facility care visits.

D. Modifier 25

MHI will reimburse for Modifier 25 when the following conditions apply:

1. **Preventive Medicine Visits with Problem-Oriented Visits**
   MHI will reimburse a preventive visit with a problem oriented visit when the modifier 25 is applied to the problem-oriented visit. Reimbursement for the preventive visit will be made at 100% of the contracted rate and reimbursement of the problem-oriented service will be made at 50% of the contracted rate.
   - This should only occur only when the preexisting problem or

abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service.
- Work performed as part of the preventive visit cannot be included in the time spent or supporting documentation of the problem-oriented E&M service.
- Modifier 25 cannot be appended to 99211.
- Both services are to be submitted on one claim.

2. Office or outpatient procedure with E&M Services

MHI will reimburse an E&M on the day of an office or outpatient procedure when the physician renders a significant, separately identifiable service above and beyond the other services provided or services beyond the usual preoperative and post-operative care associated with the procedure that was performed.
- Modifier 25 is not to be used with E&M services associated with the surgical procedure performed.
- It is not expected that a separate and distinct E&M service be performed when diagnostic and/or therapeutic services (i.e., colonoscopy), lesion removal, or injection procedures are already scheduled or when the surgical procedure is the purpose for the patient encounter.
- Documentation must clearly support the extra and/or unusual work.

E. Office visits in a Hospital or Outpatient Clinic

Refer to Provider Based Billing Payment Policy

F. Counseling Risk Factor Reduction and Behavior Change Intervention

Counseling codes 99401-99404 may be used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury.
- Counseling codes cannot be billed with another E&M code. Preventive counseling done during any other visit is considered bundled into the visit and not billed separately.
- These codes cannot be used to report counseling and risk factor reduction intervention provided to patients with symptoms or established illness.
- Documentation must include the content of the counseling session and the time spent.

G. E&M services during a Global Period
- MHI will not reimburse an E&M code billed during a global surgical period.
- MHI follows CMS when assigning a global period.
- Services rendered during the global period that are distinct from the primary procedure will be reimbursed if documentation supports the service and when modifier 24 is appended.

- MHI has a global payment policy for obstetric care. Refer to Obstetric Care Payment Policy

H. Prolonged Services

Prolonged Services codes 99354-99359 will not be reimbursed. Payment will be considered after review of documentation.

- Services must be at least 30 minutes or longer beyond the typical time of the base E&M.
- Supporting documentation must have start and stop times clearly indicated.
- Unaccompanied time, or time spent with office staff is not included.
- Time spent counseling the patient during an E&M service is not reimbursed as a prolonged service.

I. After Hours, Weekends and Holidays

MHI will provide additional compensation to physicians for seeing patients in situations that would otherwise require more costly urgent care or emergency room settings by reimbursing CPT codes 99050, 99051 in addition to basic services.

- For the purpose of this policy, holidays are: New Year's Day, President's Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Thanksgiving Day and Christmas Day.
- MHI defines regularly scheduled office hours as Monday through Friday 8:00 a.m. to 5:00 p.m.
- Urgent Care Centers cannot bill the above codes during the normal operating hours of the practice including evening and weekend hours

MHI will not separately reimburse the following services:

- 99053: Services provided 10:00 p.m. to 8:00 a.m. at a 24-hour facility, in addition to basic service.
- 99056: Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service.
- 99058: Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
- 99060: Services(s) provided on an emergency basis out of the office, which disrupts the other scheduled office services, in addition to basic service.

J. Team Conferences and Telephone Conferences

- Medical Team conference codes 99366-99368 are reimbursed. Documentation must support CPT guidelines
- Telephone Services:
- 99441-99443 and 98966-98968 are limited to reimbursement three times per calendar year. Documentation must support CPT guidelines.

- On-line Medical Evaluation cede 99444 is reimbursed. Documentation must support CPT guidelines

K. Critical Care Services
- MHI reimburses all Critical Care Services in accordance with CPT guidelines
- MHI will not separately reimburse the following services:
  - Emergency department E/M service billed with a critical care service rendered by the same provider on the same date of service
  - Critical Care Services (99291 and 99292) when submitted with Neonatal or Pediatric Critical Care Services by the same provider on the same date of service.
  - Evaluation and Management Services billed with a Critical Care Service on the same provider on the same date of service
- MHI will reimburse only one critical care or intensive care service on the same date by the same provider or physician group.

L. MHI does not reimburse the following codes:
- 99075: Medical Testimony
- 99080: Special Reports
- 99082: Unusual travel
- 99090: Analysis of data stored in a computer
- 99360: Standby services

AUTHORIZATION REQUIREMENTS

Refer to the Provider Manual for guidance on prior authorization requirements.

ATTACHMENTS

Not applicable.

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

Providers are responsible for submission of accurate claims. All EDI claims must be submitted in accordance with HIPAA 5010 Standards and Paper claims must be submitted on either CMS1500 or CMS1450 (UB04) claim forms. MHI's reimbursement policy includes the use of Current Procedural Terminology (CPT®[1]), guidelines from the Centers for Medicare and Medicaid Services (CMS), and other coding guidelines. Providers will be reimbursed based on the codes(s) that correctly describe the health care services provided.

MHI may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to MHI enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, the type of provider agreement and the terms of that agreement, the MHI Provider Manual, and/or the enrollee's benefit coverage documents.

MHI reserves the right to audit any provider and/or facility to ensure compliance with the guidelines stated in this payment policy in accordance with our provider review policy.

MHI reserves the right to modify this Payment Policy in its sole discretion.

[1] CPT® is a registered trademark of the American Medical Association.

RESOURCES

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
MHI Provider Manual

SUMMARY OF CHANGES

03/16/2017: No changes

REVIEW DATES

Updated 11/1/2015, 11/1/2016, 03/16/2017