TrailBlazer
HEALTH ENTERPRISES, LLC

Evaluation and Management Services

Published December 2010

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Part B

☆ ☆ IMPORTANT ☆ ☆

The information provided in this manual was current as of November 2010. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after November 2010, are available at:

http://www.trailblazerhealth.com/Medicare.aspx

Provider Outreach and Education
SH

☆ ☆ IMPORTANT ☆ ☆

Evaluation and Management Services

Table of Contents

Evaluation and Management Services

Evaluation and Management Services

Evaluation and Management Services

PRIMARY CARE OVERVIEW

A primary care physician is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.

Primary care includes health promotion; disease prevention; health maintenance; counseling; patient education; and diagnosis and treatment of acute and chronic illnesses in a variety of health care settings such as office, emergency room, hospital, home, skilled nursing facility or nursing home.

Charges for Missed Appointments

Physicians and suppliers are allowed to charge Medicare beneficiaries for missed appointments if they also charge non-Medicare patients for missed appointments. The amount charged for the missed appointment must apply equally to all patients (Medicare and non-Medicare). Charges to beneficiaries for missed appointments should not be billed to Medicare.

DIAGNOSIS OVERVIEW

ICD-9-CM Codes

- Physicians and Non-Physician Practitioners (NPP) must use the appropriate diagnosis code or codes to identify symptoms, conditions, problems, complaints or other reasons for the encounter or visit.
- Claims will be returned as unprocessable when the ICD-9-CM code is invalid.

Rules for Reporting Diagnosis Codes

- Use the ICD-9-CM code that describes the patient's diagnosis, symptom, complaint, condition or problem. Do not code a suspected diagnosis.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable.
- Code a chronic condition as often as applicable to the patient's treatment. Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment. Do not code conditions that no longer exist.

ICD-9-CM Codes and Date of Service

The ICD-9-CM codes must be coded to the highest level of specificity for the date of service, i.e., coding to the fourth or fifth digit. This is a requirement for all physician and NPP claims.

Diagnosis codes must be reported based on the date of service on the claim and not the date the claim is prepared or received.

Updated ICD-9-CM codes are effective each October 1.

Determining the Appropriate Primary ICD-9-CM Diagnosis Code for Diagnostic Tests Ordered Due to Signs and/or Symptoms

- **Confirmed Diagnosis Based on Results of Test:**

  If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.

Evaluation and Management Services

Example 1: A surgical specimen is sent to a pathologist with a diagnosis of "mole." The pathologist personally reviews the slides made from the specimen and makes a diagnosis of "malignant melanoma." The pathologist should report a diagnosis of "malignant melanoma" as the primary diagnosis.

Example 2: A patient is referred to a radiologist for an abdominal Computed Tomography (CT) scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess. The radiologist should report a diagnosis of "intra-abdominal abscess."

Example 3: A patient is referred to a radiologist for a chest X-ray with a diagnosis of "cough." The chest X-ray reveals a 3 cm peripheral pulmonary nodule. The radiologist should report a diagnosis of "pulmonary nodule" and may sequence "cough" as an additional diagnosis.

- **Signs or Symptoms:**

  If the diagnostic test did not provide a definitive diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

  Example 1: A patient is referred to a radiologist for a spine X-ray due to complaints of "back pain." The radiologist performs the X-ray and the results are normal. The radiologist should report a diagnosis of "back pain" since this was the reason for performing the spine X-ray.

  Example 2: A patient is seen in the emergency room for chest pain. An EKG is normal and the final diagnosis is chest pain due to suspected Gastroesophageal Reflux Disease (GERD). The patient was told to follow up with his primary care physician for further evaluation of the suspected GERD. The primary diagnosis code for the EKG should be chest pain. Although the EKG was normal, a definitive cause for the chest pain was not determined.

- **Diagnosis Preceded by Words That Indicate Uncertainty:**

  If the results of the diagnostic test are normal or non-diagnostic and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probable, suspected, questionable, rule out or working), then the interpreting physician should not code the referring diagnosis. Rather, the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as uncertain are considered by the ICD-9-CM coding guidelines as unconfirmed and should not be reported. This is consistent with the

requirement to code the diagnosis to the highest degree of certainty.

Example: A patient is referred to a radiologist for a chest X-ray with a diagnosis of "rule out pneumonia." The radiologist performs a chest X-ray and the results are normal. The radiologist should report the sign(s) or symptom(s) that prompted the test (e.g., cough).

Test Orders

The referring physician is required to provide diagnostic information to the testing entity at the time the test is ordered. The physician who is treating the patient must order all diagnostic tests.

An "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed or faxed to the testing facility.
- A telephone call by the treating physician/practitioner or his office to the testing facility. **Note:** If the order is communicated via telephone, both the treating physician/practitioner or his office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

  Or,
- An electronic mail by the treating physician/practitioner or his office to the testing facility.

Incidental Findings

Incidental findings should never be listed as primary diagnoses. If reported, incidental findings may be reported as secondary diagnoses by the physician interpreting the diagnostic test.

Diagnostic Tests Ordered in the Absence of Signs and/or Symptoms

When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the testing facility or the physician interpreting the diagnostic test should report the screening code as the primary diagnosis code. Any condition discovered during the screening should be reported as a secondary diagnosis.

Requirements That Certain Tests Must Be Ordered by the Treating Physician

Internet-Only Manual (IOM) 100-08, Chapter 3, Section 3.4.1.1D

All diagnostic X-ray services, diagnostic laboratory services and other diagnostic services must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

LOCAL COVERAGE DETERMINATIONS (LCDS)

In the absence of a national policy, Medicare contractors may use discretion to establish medical policy, currently known as Local Coverage Determinations (LCDs). Each Medicare contractor may develop LCDs pertinent to their areas of jurisdiction. Section 522 of the Benefits Improvement and Protection Act (BIPA) created the term "Local Coverage Determination." An LCD is a decision by a Medicare contractor whether to cover a particular service on a contractor-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (e.g., a determination as to whether an item or service is reasonable and necessary). TrailBlazer Health Enterprises® maintains all final LCDs on its Web site at:

http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1

EVALUATION AND MANAGEMENT (E/M) SERVICES

Overview

Important – Physicians/practitioners should use either the 1995 or 1997 Evaluation and Management Documentation Guidelines. Links to the guidelines can be found at:

http://www.trailblazerhealth.com/Specialty Services/Evaluation and Management

- CPT codes are used to report Evaluation and Management (E/M) services.
- Medical necessity must be met in addition to the individual requirements of the CPT code.
- It is not medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is all that is needed.
- The documentation should support the level of service reported.
- The service should be documented during or as soon as practicable after it is provided to maintain an accurate medical record.
- Select the code for the service based on the content of the service.
- The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in "Selection of Level of E/M Service Based on Duration of Coordination of Care and/or Counseling."
- Any physician or Non-Physician Practitioner (NPP) authorized to bill Medicare services will be paid based on the Medicare Physician Fee Schedule (MPFS).
- "Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met. For complete information, refer to the *'Incident to' Services* training manual located on the TrailBlazer℠ Web site at http://www.trailblazerhealth.com/Publications/Training Manual/incident_to.pdf.
- Refer to IOM Pub. 100-04, Chapter 12 for additional information about Medicare guidelines for E/M services.

Scribed Services

A scribe can be an NPP, nurse or other appropriate auxiliary personnel allowed by the physician to document his services in the patient's medical record. Whereas the physician or other qualified licensed practitioner must perform the medical service, the scribe may simply record its documentation. Such documentation must clearly indicate who performed the service, who recorded the service and the qualifications (i.e., professional degree, medical title, etc.) of each individual. Further, the documentation must be signed by both the physician and scribe.

Evaluation and Management Services

Example of a scribed service:

Leslie Smith, a registered nurse, accompanies Dr. Jones during his hospital rounds. Both the physician and the nurse are at the patient's bedside, where the physician takes the history, performs the examination, makes medical decisions and provides necessary patient education. The nurse documents the progress note and physician's orders as dictated by the physician.

When documentation of the service above includes a statement such as "Leslie Smith, RN, recording E/M service performed by Jay B. Jones, MD" and is signed by both Nurse Smith and Dr. Jones, the record demonstrates a properly annotated scribed service. Such a service when performed by a physician, but documented by a non-physician, could be reimbursed by Medicare. Had Nurse Smith not explicitly noted Dr. Jones' performance of the service, the service would have been neither reportable to nor payable by Medicare.

Consider the case with a few changes, as follows:

Pat Brown, a licensed Nurse Practitioner (NP), accompanies Dr. Jones during his hospital rounds. Both the physician and the NP are at the patient's bedside where the physician takes the history, performs the examination, makes medical decisions and provides the necessary patient education. The NP documents the progress note and physician's orders as dictated by the physician.

Again, when the NP's documentation demonstrates explicitly Dr. Jones' performance of any or all of the Evaluation and Management (E/M) service (except the recording), the service is payable to Dr. Jones as either his personal service or as an E/M service split-shared with the NP. However, without clear description of Dr. Jones' personal service (even if his signature is present), the service is payable only if reported by the NP and paid to her at the reduced payment rate of 85 percent of the full fee schedule amount.

Similarly, for an E/M service performed in the outpatient setting with clear documentation of the physician's personal service, payment may be made at 100 percent of the fee schedule to Dr. Jones (under "incident to"/split-shared payment rules). However, without explicit documentation of Dr. Jones' personal service, split-shared billing is not appropriate; payment may only be made if the service is reported by the NP. If Dr. Jones did not personally perform any part of the E/M service but directly supervised the service of the NP (and met all other "incident to" requirements), it is still possible for Medicare to consider payment to Dr. Jones at 100 percent of the fee schedule allowable under the "incident to" benefit category.

Scribed services may be performed in any setting, but they are most commonly used in an inpatient hospital. TrailBlazer expects the use of a scribe to be clinically appropriate

Evaluation and Management Services

for each situation and in accordance with all applicable state and federal laws governing the relevant professional practice, hospital bylaws and any other applicable regulations.

Signature Requirements

IOM 100-08, Chapter 3, Section 3.4.1.1B

Medicare requires a legible identifier for services provided/ordered. The method used must be handwritten or an electronic signature (stamped signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.

Exception: Facsimile of original written or electronic signatures is acceptable for the certifications of terminal illness for hospice.

Providers using electronic systems should recognize that there is a potential for misuse or abuse with alternate signature methods. Facsimile and hard copies of a physician's electronic signature must be in the patient's medical record for the certification of terminal illness for hospice. For example, providers need a system and software products that are protected against modification, etc., and should apply administrative procedures that are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested. Physicians should check with their attorneys and malpractice insurers regarding the use of alternative signature methods.

All state licensure and state practice regulations continue to apply. Where state law is more restrictive than Medicare, the state law standard will apply. The signature requirements described here do not assure compliance with Medicare conditions of participation.

Note: This instruction does not supersede the prohibition for Certificates of Medical Necessity (CMNs) and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Information Forms (DIFs). CMNs and DIFs are forms used to determine if the medical necessity and applicable coverage criteria for Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS) have been met.

Acceptable and Unacceptable Documentation Signatures

As a reminder, the treating physician's signature must be present in the documentation associated with all services submitted to Medicare. Medicare requires the signature be a legible identifier for the provided/ordered services.

The physician's signature can be in the form of either a handwritten signature or an electronic signature. Stamped signatures (i.e., rubber stamps) are not acceptable signatures.

Evaluation and Management Services

The following list provides examples of acceptable electronic signatures:

- Chart “Accepted by” with provider’s name.
- “Electronically signed by” with provider’s name.
- “Verified by” with provider’s name.
- “Reviewed by” with provider’s name.
- “Released by” with provider’s name.
- “Signed by” with provider’s name.
- “Signed before import by” with provider’s name.
- “Signed: John Smith, M.D.” with provider’s name.
- Digitalized signature: Handwritten and scanned into the computer.
- “This is an electronically verified report by John Smith, M.D.”
- “Authenticated by John Smith, M.D.”
- “Authorized by: John Smith, M.D.”
- “Digital Signature: John Smith, M.D.”
- “Confirmed by” with provider's name.
- “Closed by” with provider’s name.
- “Finalized by” with provider’s name.
- “Electronically approved by” with provider’s name.

Examples of acceptable handwritten signatures:

- The handwritten signature must be legible.
- The handwritten signature must clearly identify the provider performing the billed services.

Examples of unacceptable signatures:

- The legible signature is missing from the documentation.
- The signature is illegible.
- The signature cannot be verified as that of the performing provider.
- The signature is typewritten but not authenticated by either a handwritten signature or an electronic signature.
- The provider’s letterhead does not constitute legible identification.
- The provider’s initials do not constitute legible identification.

Consultation Services

Effective January 1, 2010, the CPT consultation codes (ranges 99241–99245 and 99251–99255) are no longer recognized for Medicare Part B payment. For services furnished on or after January 1, 2010, providers should code an E/M visit with E/M

Evaluation and Management Services

codes that represent where the visit occurs and that identify the complexity of the visit performed. Refer to MLN Matters® article 6740 at:

http://www.cms.gov/MLNMattersArticles/downloads/MM6740.pdf

The 2010 Consultation Reference Guide is located at:

http://www.trailblazerhealth.com/Publications/Job Aid/2010ConsultationReferenceGuide.pdf

In the inpatient hospital setting and the nursing facility setting, all physicians (and qualified non-physician practitioners 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's 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 and subsequent nursing facility care visits. In the CAH setting, those CAHs that use method II shall bill the appropriate new or established visit code for those physicians and non-physician practitioners who have reassigned their billing rights, depending on the relationship status between the physician and patient.

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 non-physician practitioners shall follow the E/M documentation guidelines for all E/M services. These rules are applicable for Medicare secondary payer claims as well as for claims in which Medicare is the primary payer.

Skilled Nursing Facility and Nursing Facility Reporting of Physician Consultation Services

If a physician or non-physician practitioner is furnishing that practitioner's first E/M service for a Medicare beneficiary in a SNF or NF during the patient's facility stay, even if that service is provided prior to the federally mandated visit, the practitioner may bill the most appropriate E/M code that reflects the services the practitioner furnished, whether that code be an initial nursing facility care code (CPT codes 99304–99306) or subsequent nursing facility care code (CPT codes 99307–99310) if documentation and medical necessity do not meet the requirements for billing an initial nursing facility care code. Prior to January 1, 2010, this service may have been reported and paid using a CPT consultation code.
JSM 11080, 12-03-10

Selection of Level of E/M Service Based on Duration of Coordination of Care and/or Counseling

Time is the key factor in selecting the level of service when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/ patient encounter or floor time (in the case of inpatient services). In general, the physician must complete at least two out of three criteria applicable to the type/level of service provided to bill an E/M code. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

Example: A cancer patient has had all preliminary studies completed and a medical decision is made to implement chemotherapy. At an office visit, the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face 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 on 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.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

Evaluation and Management Services

Use of Highest Levels of E/M Codes

- To bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet the CPT's definition of a comprehensive history).
- The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient's medical, family and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.
- The comprehensive examination may be a complete single-system exam such as cardiac, respiratory, psychiatric or a complete multi-system examination.

Shared E/M Services

Office/Clinic Setting

- When the physician performs the E/M service, the service must be reported using the physician's National Provider Identifier (NPI).
- When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, Physician Assistant (PA), Clinical Nurse Specialist (CNS) or Certified Nurse Midwife (CNM)), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient.
- If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's NPI.

Hospital Inpatient/Outpatient/Emergency Department Setting

- When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's NPI.
- If there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record), the service may only be billed under the NPP's NPI.

Examples of Shared Visits

- If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.
- In an office setting, the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met,

the service must be reported using the NPP's NPI.

Physicians in Group Practice

- Physicians of the same specialty in the same group practice must bill and be paid as a single physician.
- If more than one E/M (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 in the same group, only one E/M service may be reported unless the E/M services are for unrelated problems. (Refer to instructions for use of the 76 modifier.)
- 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.
- Physicians in different specialties in the same group practice may bill and be paid without regard to their membership in the same group.

Medical Necessity of E/M Services

Title XVIII of the Social Security Act, Section 1862(a)(1)(A), indicates that no payment may be made for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. This "medically reasonable and necessary" requirement applies to all services, including E/M services.

Medical necessity of E/M services is generally expressed in two ways: frequency of services and intensity of service (CPT level). The practitioner's documentation of E/M services reported to Medicare must demonstrate that the frequency of the E/M service and the intensity of the service were appropriate considering the nature of the patient's complaint and the patient's condition. As always, documentation intended to support all aspects of services billed to Medicare (including medical necessity) should be legible, maintained in the patient's medical record and must be made available to Medicare upon request. At an audit, Medicare will deny or downcode E/M services that, in its judgment, exceed the patient's documented needs.

Medicare's determination of medical necessity is separate from its determination that the E/M service was rendered as billed (i.e., that the level of E/M service billed was actually documented to have been provided). Medicare judges the provision of the service based on CPT E/M code definitions and CMS E/M Service Documentation Guidelines (1995 and 1997 versions). Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.

In that no one characteristic of an E/M service always defines its medical necessity, Medicare considers multiple attributes of the service when making a medical necessity

determination. Information Medicare uses is contained within the medical record documentation of history, examination and medical decision-making. The attributes include:

- The number of problems for which the physician's work of E/M is clearly demonstrated.
- Physical scope encompassed by the problems (number of physical systems affected by the problems) evaluated and managed.
- Acuity and/or duration of the problems evaluated and managed and the context among all other services previously rendered for the problems in which the current service falls.
- Severity of problems (risk for morbidity and/or mortality) evaluated and managed.
- Complexity of documented comorbidities that have been documented to have clearly influenced physician work.

For example, Medicare judges an E/M visit at which a single, chronic, well-controlled problem is evaluated and managed to be a visit that, regardless of how much history and examination is documented, is a low-intensity service based on medical necessity. Likewise, Medicare judges that such a visit remains a low-intensity service even for patients with multiple chronic diagnoses unless the record specifically demonstrates additional physician work performed because the additional chronic conditions complicated the condition under evaluation or they were otherwise specifically managed at the visit.

CPT provides two methods of guidance for coding E/M services based on medical necessity. The first guidance is CPT's contributory factor statement known as "nature of presenting problems" for most CPT E/M codes. The second medical necessity assistance in CPT is guidance found within Appendix C – Clinical Examples. The clinical examples in this appendix are designed to represent the physician work that is reasonable and necessary to provide appropriate patient care in the specified clinical circumstance of the example. Users of these examples must understand, however, that the examples serve as guides to medical necessity only, and Medicare expects actual documentation of all services billed to Medicare to also satisfy CMS documentation requirements to demonstrate the service billed was provided.

Modifiers

AI Modifier

Principal Physician of Record: Effective for dates of service on or after January 1, 2010, modifier AI should be used by the admitting or attending physician who oversees the patient's care, as distinct from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier AI in addition to the initial visit code. All other physicians who perform an initial

evaluation on this patient shall bill only the E/M code for the complexity level performed.

Note: The primary purpose of this modifier is to identify the principal physician of record on the initial hospital and nursing home visit codes.

See the MNL Matters® article MM6740 for more information: http://www.cms.gov/MLNMattersArticles/downloads/MM6740.pdf

25 Modifier **Significant separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service**

The following conditions must be met to report modifier 25:

- **The patient's condition required a significant, identifiable E/M service above and beyond** the other service provided or **services beyond the usual preoperative and postoperative care** associated with the procedure that was performed.
- These circumstances may be reported by adding the 25 modifier to the appropriate level of the E/M service.

In the conditions above, the bold areas indicate the key phrases for the proper use of the modifier.

1. The phrase, "the patient's condition required" is extremely important. In other words, it was medically necessary for the patient to have these extra services on the same day that another procedure or service was performed.
2. The phrase, "a significant, separately identifiable E/M service above and beyond" the other service provided indicates that this extra service was clearly different from the other procedure or service that was performed.
3. The phrase, "services beyond the usual preoperative and postoperative care" associated with the procedure emphasizes the fact that all procedures as defined in the Resource-Based Relative Value Scale (RBRVS) system of reimbursement that Medicare uses include a certain amount of preoperative and postoperative care in the reimbursement package. The 25 modifier should be used if extra work beyond the usual is performed. A good standard for judging whether the 25 modifier should be used is: If a physician in the same specialty area would agree after reading the clinical record that extra preoperative and/or postoperative work beyond what is usually performed with that service was performed, then it is proper to use the 25 modifier to indicate that extra work. To document the extra work performed, the clinical record should clearly indicate that extra or unusual work.

Evaluation and Management Services

Primary considerations for modifier 25 usages are:

- Why is the physician seeing the patient?
  - If the patient exhibits symptoms from which the physician diagnoses the condition and begins treatment by performing a minor procedure or an endoscopy on that same day, modifier 25 should be added to the correct level of E/M service.
  - If the patient is present for the minor procedure or endoscopy only, modifier 25 does not apply.
  - If the E/M service was to familiarize the patient with the minor procedure or endoscopy immediately before the procedure, modifier 25 does not apply.
- If the E/M service is related to the decision to perform a major procedure (90-day global), modifier 25 is not appropriate. The correct modifier is modifier 57, decision for surgery.
- When determining the level of visit to bill when modifier 25 is used, physicians should consider only the content and time associated with the separate E/M service, not the content or time of the procedure.

Examples of Proper Use of the 25 Modifier

Example 1: A patient has a nosebleed. The physician performs packing of the nose in the office, which stops the bleeding. At the same visit, the physician then evaluates the patient for moderate hypertension that was not well controlled and adjusts the antihypertensive medications.

The 25 modifier may be reported with the appropriate level of E/M code in addition to the minor procedure. The hypertension E/M was medically necessary, significant and a separately identifiable service performed on the same day as control of the nosebleed. The hypertension was exacerbating the nosebleed and was actually related to the nosebleed, but management of the hypertension was a separate service from actually packing the nose.

Example 2: A patient presents to the physician with symptoms of urinary retention. The physician performs a thorough E/M service and decides to perform a cystourethroscopy. Cystourethroscopy is performed the same day as the E/M code.

The 25 modifier may be reported with the appropriate level of E/M code in addition to the cystourethroscopy. The physician had to evaluate the patient based on the symptoms and decides on the procedure to be performed. The procedure was then performed on the same day as the E/M.

Evaluation and Management Services

Examples of Improper Use of the 25 Modifier

Example 1: A patient has a small skin cancer of the forearm removed in the physician's office. This is a routine procedure and no other conditions are treated.

The office visit is considered part of the surgery service and, therefore, not separately reimbursable. The use of the 25 modifier is inappropriate. Only the surgical procedure should be reported.

Example 2: A patient visits the physician on Monday with symptoms of GI bleeding. The physician evaluates the patient and bills an E/M service. The physician tells the patient to return on Wednesday for a sigmoidoscopy. On Wednesday, a sigmoidoscopy is performed in a routine manner.

An E/M service (no modifier applied) may be billed for the service provided on Monday. However, a separate E/M service should not be reported for Wednesday when the patient returned for the sigmoidoscopy.

Key Points

- Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician/practitioner in the patient's medical record to support claims for payment of the E/M service and the procedure with the global fee period. This documentation must be made available if requested by the carrier.
- The 25 modifier should be used to designate a significant, separately identifiable E/M service provided by the same physician/practitioner on the same patient on the same day as another procedure or service with a same-day or 10-day global period.
- The 25 modifier identifies a significant, separately identifiable E/M service. It should be used when the E/M service is above and beyond the usual pre- and postoperative work of a procedure with a same-day or 10-day global fee period performed on the same day as the E/M service.
- Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service with a global fee period. Modifier 25 should be added to the E/M code on the claim.

24 Modifier — Unrelated evaluation and management service by the same physician during a postoperative period

Use modifier 24 when an E/M service is performed during a postoperative follow-up period for reasons unrelated to the original minor or major procedure.

Evaluation and Management Services

The physician must indicate that the services billed are unrelated and not part of the postoperative diagnoses.

Examples of Related Diagnoses

Example 1: A surgical claim was billed with ICD-9-CM code 1622 (malignant neoplasm of trachea, bronchus and lung; main bronchus). Ten days later, a claim (for dates of service 10 days after a 90-day global surgery) is submitted by the same physician for an office visit and the ICD-9-CM used on the claim is 486 (pneumonia, organism unspecified).

This E/M service would be considered part of the global period and would not be payable.

Example 2: A surgical claim was billed with ICD-9-CM code 59653 (paralysis of the bladder). Eighty days later, a claim (for dates of service 80 days after a 90-day global surgery) is submitted by the same physician for an office visit and the ICD-9-CM code used on the claim was 78900 (abdominal pain, unspecified site).

This E/M service would be considered part of the global period and would not be payable.

Examples of Unrelated Diagnoses

Example 1: A surgical claim is billed with ICD-9-CM code 38421 (central perforation of tympanic membrane – ear drum). Two months later (during the 90-day global period), an E/M service is billed with ICD-9-CM code 3804 (impacted cerumen – ear wax).

This E/M service would be considered unrelated and would be payable.

Example 2: A surgical claim is billed with two 90-day global surgical codes for date of service July 9. The ICD-9-CM diagnoses submitted on the claim are 5533 (diaphragmatic hernia) and 56210 (diverticulosis of colon). An E/M service is performed and billed for date of service July 26. The ICD-9-CM codes submitted are 7872 (dysphagia – difficulty in swallowing), 7015 (other granulation tissue) and 78079 (other malaise and fatigue).

This E/M service would be considered unrelated and would be payable.

If the E/M service is unrelated to the postoperative follow-up period, modifier 24 is appropriate.

Evaluation and Management Services

57 Modifier **Decision for surgery made within global surgical period**

- E/M services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.
- In addition to the CPT E/M code, modifier 57 (decision for surgery) is used to identify a visit that results in the initial decision to perform surgery.
- If E/M services occur on the day of surgery, the physician bills using modifier 57, not 25. The 57 modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, when the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.
- An E/M service on the same day of or on the day before a procedure with a 90-day global surgical period is covered if the physician uses CPT modifier 57 to indicate that the service resulted in the decision to perform the procedure. Payment may not be made for an E/M service billed with the 57 modifier if it was provided on the day of or the day before a procedure with a zero- or 10-day global surgical period.

76 Modifier **Repeat procedure by same physician: use to indicate that a procedure or service was repeated subsequent to the original service**

- Use the 76 modifier when billing for separate office or outpatient E/M visits that occur on the same date of service (only for codes 99211–99215) by the same physician/practitioner.
- Each service should be clearly documented.
- Use the 76 modifier to indicate a separate encounter occurred on the same date of service when separate services are billed. Do not use the 76 modifier for the initial visit.

Example of Proper Usage

A patient visits the physician on Wednesday morning for a bladder infection. She is treated and sent home. That same afternoon, the patient returns to the physician's office with a twisted ankle. Each service should be reported with the appropriate level of E/M service with the 76 modifier added to the second visit for the twisted ankle.

E/M Resources

The Evaluation and Management Services Web page on the TrailBlazer Web site, http://www.trailblazerhealth.com/Specialty Services/Evaluation and

Evaluation and Management Services

Management/default.aspx?DomainID=1, contains links to the documentation guidelines as well as coding and documentation resources such as the “Coding and Documentation Pocket Reference.

Office/Outpatient Visits

Codes (Refer to the current CPT book for complete CPT code descriptions.)

New Patient Visit Codes

99201–99205

Established Patient Visit Codes

99211–99215

New Patient Visits

A “new patient” means a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.

If no E/M service is performed, the patient may continue to be treated as a new patient. For example, if a professional component of a previous procedure is billed in a three-year time period, e.g., a lab interpretation is billed and no E/M service is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an X-ray or EKG, etc., in the absence of an E/M service does not affect the designation of a new patient.

New patient visits are not included in the global period of a surgical procedure.

Visits Provided on Same Day for Unrelated Problems

As for all other E/M services except where specifically noted, two E/M office visits billed by the same physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day may not be paid unless the physician documents that the visits were for unrelated problems in the office or outpatient setting that could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

Office/Outpatient or Emergency Department Visit on Day of Admission to Nursing Facility

A physician may not be paid for an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day. The E/M services on the same date provided in sites other than the nursing facility are bundled into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician.

Evaluation and Management Services

Drug Administration Services and E/M Visits Billed on Same Day of Service

CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or non-chemotherapy drug infusion code, or therapeutic or diagnostic injection code. Therefore, when a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed in addition to a drug administration, the appropriate E/M CPT code should be reported with the 25 modifier. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required.

Documentation Requirements for 99211

CPT code 99211 is a code used to report a low-level E/M service. Code 99211 requires a face-to-face patient encounter but when billed as an "incident to" service, it may be performed by ancillary staff and billed as if the physician personally performed the service.

The CPT book defines code 99211© as:

> "Office or other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services."

Code 99211 requires a face-to-face patient encounter; however, when billed as an "incident to" service, the physician's service may be performed by ancillary staff and billed as if the physician personally performed the service. For such instances, all billing and payment requirements for "incident to" services must be met.

As with all services billed to Medicare, code 99211 services billed to Medicare must be reasonable and necessary for the diagnosis or treatment of an illness or injury. Unlike the other E/M CPT codes, CPT does not specify completion of particular levels of work for code 99211 in terms of key components or contributory factors. Also, unlike the other E/M codes, CMS did not provide documentation requirements for code 99211 in the E/M Documentation Guidelines.

CPT code 99211 describes a service that is a face-to-face encounter with a patient consisting of elements of both evaluation and management. The evaluation portion of code 99211 is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information (historical information and/or physical data) between the provider and the patient. The management portion of code 99211 is substantiated when the record demonstrates influence by the service of patient care (medical decision-making, provision of patient education, etc.). Documentation of all code 99211 services must be legible and include the identity and credentials of the individual who provided the service.

Evaluation and Management Services

For code 99211, services performed by ancillary staff and billed by the physician as an "incident to" service, the documentation should also demonstrate the "link" between the non-physician service and the precedent physician service to which the non-physician service is incidental. Therefore, documentation of code 99211 services provided "incident to" should include the identity and credentials of both the individual who provided the service and the supervising physician. Documentation of a code 99211 service provided "incident to" should also indicate the supervising physician's involvement with the patient care as demonstrated by one of the following:

- Notation of the nature of involvement by the physician (the degree of which must be consistent with clinical circumstances of the care).
- Documentation from other dates of service that establishes the link between the services of the two providers.
- Medicare has reviewed numerous claims on which 99211 was reported inappropriately. All 99211 services whose supporting documentation does not demonstrate that an E/M service was performed and was necessary as outlined in this document will be denied upon review

Among other things, code 99211 should not be used to bill Medicare:

- For phone calls to patients.
- Solely for the writing of prescriptions (new or refill) when no other E/M is necessary or performed.
- For blood pressure checks when the information obtained does not lead to management of a condition or illness.
- When drawing blood for laboratory analysis or when performing other diagnostic tests whether a claim for the venipuncture or other diagnostic study test is submitted separately.
- Routinely when administering medications whether an injection (or infusion) code is submitted on the claim separately.
- For performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed or payment is bundled with payment for another service) whether or not the procedure code is submitted on the claim separately.

The table below contains elements that would constitute adequate documentation of a code 99211 service in selected clinical circumstances:

Clinical Circumstance	Adequate Documentation for Code 99211
Blood pressure check	1. Blood pressure and other vital signs recorded. 2. Clinical reason for checking blood pressure recorded (i.e., follow-up to previous abnormal finding, symptoms suggestive of abnormal blood pressure, etc.).

Evaluation and Management Services

Clinical Circumstance	Adequate Documentation for Code 99211
	3. Current medications listed (with notation of level of compliance). 4. Indication of doctor's evaluation of the clinical information obtained and his management recommendation. 5. Identity and credentials of provider(s) as listed in text above.
Prescription refill or injection/infusion	1. Reason for the visit. A physician visit is not necessary to routinely provide stable patients with an ongoing medication supply. Therefore, the documentation for code 99211 or any other E/M code in this circumstance must demonstrate a need for clinical E/M (for instance, symptoms or signs reported that are significant enough to necessitate evaluation). 2. Current medications listed (with notation of level of compliance). 3. Indication of doctor's evaluation of the clinical information obtained and his management recommendation. 4. Identity and credentials of provider(s) as listed in text above.
Prothrombin time evaluation for patients on chronic warfarin anticoagulation	1. Reason for the visit. A physician visit is not routinely necessary to draw blood for prothrombin time or other laboratory tests. Therefore, the documentation for code 99211 or any other E/M code in this circumstance must demonstrate a need for clinical E/M. In this case, services that would serve to demonstrate that E/M was performed include an evaluation of significant new symptoms (such as excessive bruising or hemorrhage). Alternatively, for patients who have no new clinical concerns, documentation that contemporaneous laboratory values were obtained, reviewed and used to guide current and/or future therapy documents that a separately payable E/M service has been performed. 2. Current medications listed (with notation of level of compliance). 3. Indication of doctor's evaluation of the information about signs/symptoms and laboratory test result and his management recommendation. 4. Identity and credentials of provider(s) as listed in text above.

Hospital Observation Services

Codes (Refer to the current CPT book for complete CPT code descriptions.)

Observation Care Discharge

99217

Evaluation and Management Services

Initial Observation Care Codes

99218–99220

Observation or Inpatient Care Services (Including Admission and Discharge Services)

99234–99236

Who May Bill Initial Observation Care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring to make a decision concerning their admission or discharge.

In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in fewer than 48 hours, usually in fewer than 24 hours.

- Payment may only be made to the physician who ordered hospital outpatient observation services and was responsible for the patient during his observation care.
- A physician who does not have inpatient admitting privileges but who is authorized to furnish hospital outpatient observation services may bill these codes.
- There must be a medical observation record for the patient that contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes and progress notes prepared by the physician while the patient received observation services. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.
- Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

Example: If an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient

must bill the new or established office or other outpatient visit codes as appropriate.

Physician Billing for Observation Care Following Initiation of Observation Services

- When a patient receives observation care for less than eight hours on the same calendar date, the initial observation care from CPT code range 99218–99220 should be reported by the physician. The observation care discharge service, CPT code 99217, should not be reported for this scenario.
- When a patient is admitted for observation care and then is discharged on a different calendar date, the physician shall report initial observation care from CPT code range 99218–99220 and CPT observation care discharge CPT code 99217.
- When a patient receives observation care for a minimum of eight hours but less than 24 hours and is discharged on the same calendar date, observation or inpatient care services (including admission and discharge services) from CPT code range 99234–99236 should be reported. The observation discharge, CPT code 99217, cannot also be reported for this scenario.

Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services (Codes 99234–99236))

The physician should satisfy the E/M documentation guidelines for furnishing observation care or inpatient hospital care. In addition to meeting the documentation requirements for history, examination and medical decision-making, documentation in the medical record shall include:

- Documentation noting the stay for observation care or inpatient hospital care involves eight hours, but less than 24 hours.
- Documentation identifying the billing physician was present and personally performed the services.
- Documentation identifying the order for observation services, progress notes and discharge notes were written by the billing physician.

In the rare circumstance when a patient receives observation services for more than two calendar dates, the physician should bill a visit furnished before the discharge date using the outpatient/office visit codes. The physician may not use the subsequent hospital care codes since the patient is not an inpatient of the hospital.

Admission to Inpatient Status Following Observation Care

- If the same physician who ordered hospital outpatient observation services also admits the patient to inpatient status before the end of the date on which the patient began receiving hospital outpatient observation services, Medicare should pay only an initial hospital visit for the E/M services provided on that date.

Evaluation and Management Services

Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service.

- The physician may not bill an initial observation care code for services on the date he admits the patient to inpatient status.
- If the patient is admitted to inpatient status from hospital outpatient observation care subsequent to the date of initiation of observation services, the physician must bill an initial hospital visit for the services provided on that date.
- The physician may not bill the hospital observation discharge management code (99217) or an outpatient/office visit for the care provided while the patient received hospital outpatient observation services on the date of admission to inpatient status.

Hospital Observation Services During Global Surgical Period

The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, 99220, 99234, 99235 and 99236) services unless the criteria for use of modifiers 24, 25 or 57 are met. These services are paid in addition to the global surgical fee only if both of the following requirements are met:

- The hospital observation service meets the criteria needed to justify billing it with modifiers 24, 25 or 57 (decision for major surgery).
- The hospital observation service furnished by the surgeon meets all the criteria for the hospital observation code billed.

Examples of the Decision for Surgery During a Hospital Observation Period

Example 1: An emergency department physician orders hospital outpatient observation services for a patient with a head injury. A neurosurgeon is called in to evaluate the need for surgery while the patient is receiving observation services and decides the patient requires surgery. The surgeon should bill a new or established office or other outpatient visit code as appropriate with the 57 modifier to indicate the decision for surgery was made during the evaluation. The surgeon must bill office or other outpatient visit code because the patient receiving hospital outpatient observation services is not an inpatient of the hospital. Only the physician who ordered hospital outpatient observation services may bill for initial observation care.

Example 2: A neurosurgeon orders hospital outpatient observation services for a patient with a head injury. During the observation period, the surgeon makes the decision for surgery. The surgeon should bill the appropriate level of hospital observation code with the 57 modifier to indicate the decision for surgery was made while the surgeon was providing hospital observation care.

Evaluation and Management Services

Examples of Hospital Observation Services During the Postoperative Period of a Surgery

Example 1: A surgeon orders hospital outpatient observation services for a patient with abdominal pain from a kidney stone on the 80th day following a Transurethral Resection of Prostate (TURP) (performed by that surgeon). The surgeon decides the patient does not require surgery. The surgeon should bill the observation code with the modifier 24 and documentation to support that the observation services are unrelated to the surgery.

Example 2: A surgeon orders hospital outpatient observation services for a patient with abdominal pain on the 80th day following a TURP (performed by that surgeon). While the patient is receiving hospital outpatient observation services, the surgeon decides the patient requires kidney surgery. The surgeon should bill the observation code with HCPCS modifier 57 to indicate the decision for surgery was made while the patient was receiving hospital outpatient observation services. The subsequent surgical procedure would be reported with modifier 79.

Example 3: A surgeon orders hospital outpatient observation services for a patient with abdominal pain on the 20th day following a resection of the colon (performed by that surgeon). The surgeon determines the patient requires no further colon surgery and discharges the patient. The surgeon may not bill for the observation services furnished during the global period because they were related to the previous surgery.

Example of a Billable Hospital Observation Service on the Same Day as a Procedure

A physician repairs a laceration of the scalp in the emergency department for a patient with a head injury and then subsequently orders hospital outpatient observation services for that patient. The physician would bill the observation code with a CPT modifier 25 and the procedure code.

Payment for Inpatient Hospital Visits

Codes (Refer to the current CPT book for complete CPT code descriptions.)

Initial Hospital Care

99221–99223

Subsequent Hospital Care

99231–99233

Hospital Discharge

99238–99239

Evaluation and Management Services

Hospital Visit and Critical Care on Same Day

When a hospital inpatient (or emergency department or office/outpatient) E/M service is furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care, both the critical care services (CPT codes 99291 and 99292) and the previous E/M service may be paid on the same date of service. Hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient.

During critical care management of a patient, those services that do not meet the level of critical care should be reported with a subsequent inpatient hospital care CPT code in the 99231–99233 range.

Both initial hospital care (CPT codes 99221–99223) and subsequent hospital care codes are per diem services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

Physicians and qualified NPPs are advised to retain documentation for discretionary contractor review should claims be questioned for both hospital care and critical care claims. The retained documentation shall support claims for critical care when the same physician or physicians of the same specialty in a group practice report critical care services for the same patient on the same calendar date as other E/M services.

Two Hospital Visits Same Day

- A physician may only be paid for one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not.
- The inpatient hospital visit descriptors contain the phrase “per day,” which means the code and the payment established for the code represent all services provided on that date.
- The physician should select a code that reflects all services provided during the date of service.

Hospital Visits Same Day But by Different Physicians

- In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, physician B should not receive payment for the second visit. The hospital visit descriptors include the phrase “per day,” meaning care for the day.
- If the physicians are each responsible for a different aspect of the patient’s care, both visits should be paid if the physicians are in different specialties and the visits are billed with different diagnoses. There are circumstances where physicians of the same specialty may bill concurrent care.

Evaluation and Management Services

Visits to Patients in Swing Beds

If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, the nursing facility codes apply.

Payment for Initial Hospital Care Services and Observation or Inpatient Care Services

Initial Hospital Care From Emergency Room

An initial hospital care service may be paid if a physician sees his patient in the emergency room and decides to admit the person to the hospital. Both E/M services should not be billed. Also, an emergency department visit by the same physician on the same date of service is not covered.

When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.

Initial Hospital Care on Day Following Visit

Both visits are covered if a patient is seen in the office on one date and admitted to the hospital on the next date, even if fewer than 24 hours have elapsed between the visit and the admission.

Initial Hospital Care and Discharge on the Same Day

When a patient is admitted to inpatient hospital care for less than eight hours on the same date, the physician should report the initial hospital care from CPT code range 99221–99223. The hospital discharge day management service, CPT codes 99238 or 99239, should not be reported for this scenario.

When a patient is admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician should report an initial hospital care from CPT code range 99221–99223 and a hospital discharge day management service of CPT code 99238 or 99239.

When a patient has been admitted to inpatient hospital care for a minimum of eight hours but less than 24 hours and discharged on the same calendar date, observation or inpatient hospital care services (including admission and discharge services) from CPT code range 99234–99236 shall be reported.

Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services), CPT Codes 99234–99236

The physician should satisfy the E/M documentation guidelines for admission to and discharge from inpatient observation or hospital care. In addition to meeting the

documentation requirements for history, examination and medical decision-making, documentation in the medical record should include:

- Documentation noting the stay for hospital treatment or observation care status involves eight hours but less than 24 hours.
- Documentation identifying the billing physician was present and personally performed the services.
- Documentation identifying the admission and discharge notes were written by the billing physician.

Physician Services Involving Transfer From One Hospital to Another

Physicians may bill both the hospital discharge management code and an initial hospital care code when the discharge and admission do not occur on the same day if the transfer is between:

- Different hospitals.
- Different facilities under common ownership, which do not have merged records.

  Or,
- Between the acute care hospital and a Prospective Payment System (PPS) exempt unit within the same hospital when there are no merged records.

In all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer.

Initial Hospital Care Service History and Physical That Is Less Than Comprehensive

When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission. Payment may be made for the office visit as billed and the Level 1 initial hospital care code.

All physicians who provide an initial visit to a patient during hospital care shall report an initial hospital care code (99221–99223). The principal physician of record shall append modifier AI, Principal Physician of Record, to the claim with the initial hospital care code. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care.

Initial Hospital Care Visits by Two Different Physicians When They Are Involved in Same Admission

In the inpatient hospital setting, all physicians (and qualified non-physician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221–99223) or nursing facility care codes (99304–99306). Only one MD or DO is

considered to be the principal physician of record (sometimes referred to as the admitting physician). The principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care. Only 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 and subsequent nursing facility care visits.

Subsequent Hospital Visits During the Global Surgery Period

The Medicare physician fee schedule payment amount for surgical procedures includes all services (E/M visits) that are part of the global surgery payment.

Hospital Discharge Day Management Service

- Hospital discharge day management services, CPT code 99238 or 99239, are a face-to-face E/M service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is payable per patient, per hospital stay.
- Only the attending physician of record reports the discharge day management service. Physicians or qualified NPPs, other than the attending physician, who have managed concurrent health care problems not primarily managed by the attending physician and who are not acting on behalf of the attending physician, shall use subsequent hospital care (CPT code range 99231–99233) for a final visit.
- Medicare pays for the paperwork of patient discharge day management through the pre- and post-service work of an E/M service.

Subsequent Hospital Visit and Discharge Management on Same Day

- Only the hospital discharge management code on the day of discharge (unless it is also the day of admission, in which case refer to "Initial Hospital Care and Discharge on Same Day" for the policy on observation or inpatient care services, including admission and discharge services codes 99234–99236).
- Physicians may not bill for both a subsequent hospital visit and hospital discharge management for the same date of service.

Hospital Discharge Management (CPT Codes 99238 and 99239) and Nursing Facility Admission Code When Patient is Discharged From Hospital and Admitted to Nursing Facility on Same Day

- Payment may be made for the hospital discharge code (code 99238 or 99239) in addition to a nursing facility admission code when billed by the same physician with the same date of service.

Evaluation and Management Services

- If a surgeon is admitting the patient to the nursing facility due to a condition that is not a result of the surgery during the postoperative period of a service with a global surgical period, he should bill for the nursing facility admission and care with modifier 24. Documentation must support that the service is unrelated to the surgery (e.g., return of an elderly patient to the nursing facility where he has resided for five years following discharge from the hospital for cholecystectomy).
- Payment may not be made for a nursing facility admission by a surgeon in the postoperative period of a procedure with a global surgical period if the patient's admission to the nursing facility is to receive postoperative care related to the surgery (e.g., admission to a nursing facility to receive physical therapy following a hip replacement). Payment for the nursing facility admission and subsequent nursing facility services are included in the global fee and cannot be paid separately.

Hospital Discharge Management and Death Pronouncement

- Only the physician who personally performs the pronouncement of death shall bill for the face-to-face hospital discharge day management service, CPT code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed even if the paperwork is delayed to a subsequent date.

Emergency Department Visits

99281–99288

Use of Emergency Department Codes by Physicians Not Assigned to Emergency Department

Any physician seeing a patient registered in the emergency department may use emergency department visit codes (for services matching the code description). It is not required that the physician be assigned to the emergency department.

Use of Emergency Department Codes in Office

Emergency department coding is not appropriate if the site of service is an office or outpatient setting or any sight of service other than an emergency department. The emergency department codes should only be used if the patient is seen in the emergency department and the services described by the code definition are provided. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

Use of Emergency Department Codes to Bill Nonemergency Services

Services in the emergency department may not be emergencies. However the codes (99281–99288) are payable if the described services are provided. However, if the physician asks the patient to meet him in the emergency department as an alternative to

the physician's office and the patient is not registered as a patient in the emergency department, the physician should bill the appropriate office/outpatient visit codes. Normally a lower level emergency department code would be reported for a non-emergency condition.

Emergency Department or Office/Outpatient Visits on Same Day as Nursing Facility Admission

Emergency department visits provided on the same day as a comprehensive nursing facility assessment are not paid. Payment for E/M services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.

Physician Billing for Emergency Department Services Provided to Patient by Both Patient's Personal Physician and Emergency Department Physician

If a physician advises his own patient to go to an Emergency Department (ED) of a hospital for care and the physician subsequently is asked by the ED physician to come to the hospital to evaluate the patient and to advise the ED physician as to whether the patient should be admitted to the hospital or be sent home, the physicians should bill as follows:

- If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes 99221–99223) because all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The ED physician who saw the patient in the emergency department should bill the appropriate level of the ED codes.
- If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician may not bill.

ED Physician Requests Another Physician to See the Patient in ED or Office/Outpatient Setting

If the ED physician requests that another physician evaluate a given patient, the other physician should bill an ED visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he should bill an initial hospital care code and not an ED visit code.

Evaluation and Management Services

Critical Care Services

Codes (Refer to the current CPT book for complete CPT code descriptions.)

Critical Care Visits and Neonatal Intensive Care Codes

99291–99292

Use of Critical Care Codes

Medicare pays for services reported with CPT codes 99291 and 99292 when all the criteria for critical care and critical care services are met. Critical care is defined as the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a **high probability of imminent or life-threatening deterioration** in the patient's condition.

Critical care involves high-complexity decision-making to assess, manipulate and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(ies), critical care may be provided in life-threatening situations when these elements are not present.

Providing medical care to a critically ill, injured or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit or the emergency department. However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care.

Consult the American Medical Association (AMA) CPT book for the applicable codes and guidance for critical care services provided to **neonates, infants and children.**

Critical Care Services and Medical Necessity

Critical care services must be medically necessary and reasonable. Services provided that do not meet critical care services or services provided for a patient who is not critically ill or injured in accordance with the above definitions and criteria, but who happens to be in a critical care, intensive care or other specialized care unit, should be reported using another appropriate E/M code (e.g., subsequent hospital care, CPT codes 99231–99233).

Evaluation and Management Services

Critical care services encompass both treatment of "vital organ failure" and "prevention of further life-threatening deterioration of the patient's condition." Therefore, although critical care may be delivered in a moment of crisis or upon being called to the patient's bedside emergently, this is not a requirement for providing critical care service. The treatment and management of the patient's condition, while not necessarily emergent, shall be required, based on the threat of imminent deterioration (i.e., the patient shall be critically ill or injured at the time of the physician's visit).

Chronic Illness and Critical Care

Examples of Patients Whose Medical Condition May Not Warrant Critical Care Services

Example 1: Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long-term management of the ventilator dependence.

Example 2: Management of dialysis or care related to dialysis for a patient receiving ESRD hemodialysis does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long-term management of the dialysis dependence (refer to Chapter 8, Section 160.4). When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed, it may be billed as critical care if critical care requirements are met. Modifier 25 should be appended to the critical care code when applicable in this situation.

Examples of Patients Whose Medical Condition May Warrant Critical Care Services

Example 1: An 81-year-old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery, he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.

Example 2: A 67-year-old female patient is three days status post-mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.

Example 3: A 70-year-old patient admitted for right lower lobe pneumococcal pneumonia with a history of Chronic Obstructive Pulmonary Disease (COPD) becomes hypoxic and hypotensive two days after admission.

Example 4: A 68-year-old patient admitted for an acute anterior wall myocardial

infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

Examples of Patients Who May Not Satisfy Medicare Medical Necessity Criteria or Do Not Meet Critical Care Criteria or Who Do Not Have a Critical Care Illness or Injury and, Therefore, Are Not Eligible for Critical Care Payment

Example 1: Patients admitted to a critical care unit because no other hospital beds were available.

Example 2: Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose).

Example 3: Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

Providing medical care to a critically ill patient should not be automatically deemed to be a critical care service for the sole reason that the patient is critically ill or injured. While more than one physician may provide critical care services to a patient during the critical care episode of an illness or injury, each physician must be managing one or more critical illness(es) or injury(ies) in whole or in part.

Example: A dermatologist evaluates and treats a rash on an Intensive Care Unit (ICU) patient who is maintained on a ventilator and nitroglycerine infusion, which are being managed by an intensivist. The dermatologist should not report a service for critical care.

Critical Care Services and Full Attention of the Physician

The duration of critical care services to be reported is the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. That time must be spent at the immediate bedside or elsewhere on the floor or unit as long as the physician is immediately available to the patient.

For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be reported as critical care, even when it does not occur at the bedside, if this time represents the physician’s full attention to the management of the critically ill/injured patient.

For any given period of time spent providing critical care services, the physician must devote his full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

Evaluation and Management Services

Critical Care Services and Qualified NPP

Critical care services may be provided by qualified NPPs and reported for payment under the NPP's NPI when the services meet the definition and requirements of critical care services. The provision of critical care services must be within the scope of practice and licensure requirements for the state in which the qualified NPP practices and provides the service(s). Collaboration, physician supervision and billing requirements must also be met. A physician assistant shall meet the general physician supervision requirements.

Critical Care Services and Physician Time

Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time critical care services were provided. More than one physician can provide critical care at another time and be paid if the service meets critical care, is medically necessary and is not duplicative care. Concurrent care by more than one physician (generally representing different physician specialties) is payable if these requirements are met (refer to the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 30 for concurrent care policy discussion).

The CPT critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated. Reporting CPT code 99291 is a prerequisite to reporting CPT code 99292. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician (Section 30.6.5).

1. **Off the Unit/Floor**
   Time spent in activities that occur outside of the unit or off the floor (i.e., telephone calls, whether taken at home, in the office or elsewhere in the hospital) may not be reported as critical care because the physician is not immediately available to the patient. This time is regarded as pre- and post-service work bundled in E/M services.

2. **Split/Shared Service**
   A split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) cannot be reported as a critical care service. Critical care services are reflective of the care and management of a critically ill or critically injured patient by an individual physician or qualified NPP for the specified reportable period of time.

   Unlike other E/M services where a split/shared service is allowed, the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified NPP and shall not be representative of a combined service between a physician and a qualified NPP.

Evaluation and Management Services

When CPT code time requirements for both 99291 and 99292 and critical care criteria are met for a medically necessary visit by a qualified NPP, the service shall be reported using the appropriate individual NPI number. A medically necessary visit(s) that does not meet these requirements shall be reported as a subsequent hospital care service.

3. **Unbundled Procedures**
   Time involved performing procedures that are not bundled into critical care (i.e., billed and paid separately) may not be included and counted toward critical care time. The physician's progress note(s) in the medical record should document that time involved in the performance of separately billable procedures was not counted toward critical care time.

4. **Family Counseling/Discussions**
   Critical care CPT codes 99291 and 99292 include pre- and post-service work. Routine daily updates or reports to family members and/or surrogates are considered part of this service. However, time involved with family members or other surrogate decision-makers, whether to obtain a history or to discuss treatment options (as described in CPT), may be counted toward critical care time when the following specific criteria are met:
   - The patient is unable or incompetent to participate in giving a history and/or making treatment decisions.
   - The discussion is necessary for determining treatment decisions.

   For family discussions, the physician should document:
   - The patient is unable or incompetent to participate in giving history and/or making treatment decisions
   - The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family").
   - Medically necessary treatment decisions for which the discussion was needed.
   - A summary in the medical record that supports the medical necessity of the discussion.

   All other family discussions, no matter how lengthy, may not be additionally counted toward critical care. Telephone calls to family members and or surrogate decision-makers may be counted toward critical care time but only if they meet the same criteria as described in the aforementioned paragraph.

5. **Inappropriate Use of Time for Payment of Critical Care Services**
   Time involved in activities that do not directly contribute to the treatment of the critically ill or injured patient may not be counted toward the critical care time, even when they are performed in the critical care unit at a patient's bedside (e.g., review

of literature and teaching sessions with physician residents whether conducted on hospital rounds or in other venues).

Hours and Days of Critical Care That May Be Billed

Critical care service is a time-based service provided on an hourly or fraction-of-an-hour basis. Payment should not be restricted to a fixed number of hours, a fixed number of physicians or a fixed number of days, on a per patient basis, for medically necessary critical care services. Time counted toward critical care services may be continuous or intermittent and aggregated in time increments (e.g., 50 minutes of continuous clock time or five 10-minute blocks of time spread over a given calendar date). Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient.

For Medicare Part B physician services paid under the physician fee schedule, critical care is not a service that is paid on a “shift” basis or a “per day” basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include: claims from several physicians submitting multiple units of critical care for a single patient; and submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date. Physicians assigned to a critical care unit (e.g., hospitalist, intensivist, etc.) may not report critical care for patients based on a “per shift” basis.

CPT code 99291 is used to report the first 30–74 minutes of critical care on a given calendar date of service. It should only be used once per calendar date per patient by the same physician or physician group of the same specialty. CPT code 99292 is used to report additional block(s) of time of up to 30 minutes each beyond the first 74 minutes of critical care. Critical care of less than 30 minutes total duration on a given calendar date should not be reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

Clinical Example of Correct Billing of Time

A patient arrives in the emergency department in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the emergency department and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the Cardiac Care Unit (CCU). In this instance, the emergency department physician provided 40 minutes of critical care services and reports only the critical care code (CPT code 99291) and not also emergency department services. The cardiologist may report the 35 minutes of critical care services (also CPT code 99291) provided in the emergency department. Additional critical care services by the cardiologist in the CCU may be reported on the same calendar date using 99292 or another appropriate E/M code depending on the clock time involved.

Evaluation and Management Services

Counting of Units of Critical Care Services

CPT code 99291 (critical care, first hour) is used to report the services of a physician providing full attention to a critically ill or critically injured patient from 30–74 minutes on a given date. Only one unit of CPT code 99291 may be billed by each physician for a patient on a given date. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician and would not each report CPT 99291 on the same date of service.

The following illustrates the correct reporting of critical care services:

Total Duration of Critical Care Codes

Fewer than 30 minutes	99232 or 99233 or other appropriate E/M code
30–74 minutes	99291 x 1
75–104 minutes	99291 x 1 and 99292 x 1
105–134 minutes	99291 x 1 and 99292 x 2
135–164 minutes	99291 x 1 and 99292 x 3
165–194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291–99292 as appropriate (per the above Illustrations)

Critical Care Services and Other E/M Services Provided on Same Day

When critical care services are required upon the patient's presentation to the hospital emergency department, only critical care codes 99291–99292 may be reported. An emergency department visit code may not also be reported.

When critical care services are provided on a date where an inpatient hospital or office/outpatient E/M service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous E/M service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient.

Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other E/M services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

Critical Care Services Provided by Physicians in Group Practice(s)

Medically necessary critical care services provided on the same calendar date to the same patient, which are not duplicative services, by physicians representing different medical specialties are payable. The medical specialists may be from the same group practice or different group practices.

Evaluation and Management Services

Critically ill or critically injured patients may require the care of more than one physician medical specialty. Concurrent critical care services provided by each physician must be medically necessary and not provided during the same instance of time. Medical record documentation must support the critical care services provided by each physician were necessary to treat and manage the critical illness(es) or critical injury(ies) of the patient. Each physician must accurately report the service(s) he provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 12, Section 40, and the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 30.)

CPT Code 99291

The initial critical care time, billed as CPT code 99291, must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical exam performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.

CPT Code 99292

Subsequent critical care visits performed on the same calendar date are reported using CPT code 99292. The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care to combine the times.

Physicians in the same group practice who have the same specialty may not each report CPT initial critical care code 99291 for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to the *Medicare Claims Processing Manual*, IOM Pub. 100-04, Chapter 12, Section 30.6.)

Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the contractor that adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative, the critical care services may be reported by each regardless of their group practice relationship.

Two or more physicians in the same group practice who have different specialties and who provide critical care to a critically ill or critically injured patient may not in all cases each report the initial critical care code (CPT code 99291) on the same date. When the group physicians are providing care that is unique to their individual medical specialty

and managing at least one of the patient's critical illnesses or critical injuries, the initial critical care service may be payable to each.

However, if a physician or qualified NPP within a group provides "staff coverage" or "follow-up" for another group physician who provided the first hour of critical care services on that same calendar date but has left the care to a second physician, the second group physician or qualified NPP should report the CPT critical care add-on code 99292 or another appropriate E/M code.

Clinical Examples of Critical Care Services

Example 1: Drs. Smith and Jones, pulmonary specialists, share a group practice. On Tuesday, Dr. Smith provides critical care services to Mrs. Benson who is comatose and has been in the intensive care unit for four days following a motor vehicle accident. She has multiple organ dysfunction including cerebral hematoma, flail chest and pulmonary contusion. Later on the same calendar date, Dr. Jones covers for Dr. Smith and provides critical care services. Medically necessary critical care services provided at the different time periods may be reported by both Drs. Smith and Jones. Dr. Smith would report CPT code 99291 for the initial visit and Dr. Jones, as part of the same group practice, would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.

Example 2: Mr. Marks, a 79-year-old male, comes to the emergency department with vague joint pains and lethargy. The emergency department physician evaluates Mr. Marks and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the emergency room and admits Mr. Marks to the observation unit for monitoring and diagnostic and laboratory tests. In observation, Mr. Marks has a cardiac arrest. His primary care physician provides 50 minutes of critical care services. Mr. Marks is admitted to the intensive care unit. On the same calendar day, Mr. Marks' condition deteriorates and he requires intermittent critical care services. In this scenario, the emergency department physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician as Critical Care Codes 99291–99292

The following services, when performed on the day a physician bills for critical care, are included in the critical care service and should not be reported separately:

- The interpretation of cardiac output measurements (CPT codes 93561 and 93562).
- Chest X-rays, professional component (CPT codes 71010, 71015 and 71020).
- Blood draw for specimen (CPT code 36415).

Evaluation and Management Services

- Blood gases and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (CPT code 99090).
- Gastric intubation (CPT codes 43752 and 91105).
- Pulse oximetry (CPT codes 94760, 94761 and 94762).
- Temporary transcutaneous pacing (CPT code 92953).
- Ventilator management (CPT codes 94002–94004, 94660 and 94662).
- Vascular access procedures (CPT codes 36000, 36410, 36415, 36591 and 36600).

No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

Global Surgery

Critical care services shall not be paid on the same calendar date the physician also reports a procedure code with a global surgical period unless the critical care is billed with CPT modifier 25 to indicate the critical care is a significant, separately identifiable E/M service that is above and beyond the usual pre- and postoperative care associated with the procedure that is performed.

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow-directed catheter, e.g., Swan-Ganz (CPT code 93503), are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier 25. The time spent performing the pre-, intra- and post-procedure work of these unbundled services, e.g., endotracheal intubation, shall be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0-, 10- or 90-day global period including Cardiopulmonary Resuscitation (CPR) (CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier 25. The time spent performing CPR shall be excluded from the determination of the time spent providing critical care. In this instance, it must be the physician who performs the resuscitation who bills for this service. Members of a code team must not each bill Medicare Part B for this service.

When postoperative critical care services (for procedures with a global surgical period) are provided by a physician other than the surgeon, no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, CPT modifiers 54 (surgical care only) and 55 (postoperative management only) must be used by the surgeon and intensivist who are submitting claims. Medical record documentation by the

surgeon and the physician who assumes a transfer (e.g., intensivist) is required to support claims for services when CPT modifiers 54 and 55 are used indicating the transfer of care from the surgeon to the intensivist. Critical care services must meet all the conditions previously described in this manual section.

Critical Care Services Provided During Preoperative and Postoperative Portions of Global Period of Procedure with 90-Day Global Period in Trauma and Burn Cases

Preoperative

Preoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the full attention of the physician, and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life-threatening deterioration in the patient's condition.

Preoperatively, two reporting requirements must be met for these services to be paid. Codes 99291–99292 and modifier 25 (significant, separately identifiable E/M services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed shall be submitted. An ICD-9-CM code in the range 800.0–959.9 (except 930.0–939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Postoperative

Postoperatively, for critical care services to be paid, two reporting requirements must be met. Codes 99291–99292 and modifier 24 (unrelated E/M service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0–959.9 (except 930.0–939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period for reasons unrelated to the surgery, these are separately payable as well.

Teaching Physician Criteria

For the teaching physician to bill for critical care services, the teaching physician must meet the requirements for critical care described in the preceding sections. For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the

teaching physician is present for the full 35 minutes. (See *Medicare Claims Processing Manual,* IOM Pub. 100-04, Chapter 12, Section 100.1.4.)

Teaching

Time spent teaching may not be counted toward critical care time. Time spent by the resident in the absence of the teaching physician cannot be billed by the teaching physician as critical care or other time-based services. Only time spent by the resident and teaching physician together with the patient or the teaching physician alone with the patient can be counted toward critical care time.

Documentation

A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment. However, the teaching physician medical record documentation must provide substantive information including: (1) time the teaching physician spent providing critical care; (2) that the patient was critically ill during the time the teaching physician saw the patient; (3) what made the patient critically ill; and (4) the nature of the treatment and management provided by the teaching physician. The medical review criteria are the same for the teaching physician as for all physicians. (See *Medicare Claims Processing Manual,* IOM Pub. 100-04, Chapter 12, Section 100.1.1 for teaching physician documentation guidance.)

Unacceptable Example of Documentation:
"I came and saw (the patient) and agree with (the resident)."

Acceptable Example of Documentation:
"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

Ventilator Management

Medicare recognizes the ventilator codes (CPT codes 94002–94004, 94660 and 94662) as physician services payable under the physician fee schedule. Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an E/M service (e.g., critical care services, CPT codes 99291–99292) on the same day for the patient even when the E/M service is billed with CPT modifier 25.

Evaluation and Management Services

Nursing Facility Services

Codes (Refer to the current CPT book for complete CPT code descriptions.)

Initial Nursing Facility Care

99304–99306

Subsequent Nursing Facility Care

99307–99310

Nursing Facility Discharge Services

99315–99316

Other Nursing Facility Services

99318

Visits to Perform Resident Assessments

Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

The distinction made between the delegation of physician visits and tasks in a Skilled Nursing Facility (SNF) and in a Nursing Facility (NF) is based on the Medicare statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while Section 1919 (b) (6) (A) of the Act governs NFs. For further information, refer to Medlearn Matters® article SE0418 at:

http://www.cms.gov/MLNMattersArticles/downloads/SE0418.pdf

The initial visit in an SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4)). The principal physician of record must append the modifier AI to the initial nursing facility care code. This modifier will identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation in the nursing facility may bill the initial nursing facility care code. The initial visit is defined as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification (S&C) requirements, a visit must occur no later than 30 days after admission.

Further, per the long-term care regulations at 42 CFR 483.40 (c) (4) and (e) (2), the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial visit in an SNF. This also applies to the NF with one exception.

Evaluation and Management Services

The only exception as to who performs the initial visit relates to the NF setting. In the NF setting, a qualified NPP (i.e., a Nurse Practitioner (NP), Physician Assistant (PA) or a Clinical Nurse Specialist (CNS) who is not employed by the facility, may perform the initial visit when state law permits this. The E/M visit shall be within the state scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision shall be met.

Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure and billing are met.

The CPT nursing facility services codes shall be used with Place of Service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (Nursing Facility) if the patient does not have Part A SNF benefits or if the patient is in an NF or in a non-covered SNF stay (e.g., there was no preceding three-day hospital stay). The CPT nursing facility code definition also includes POS 54 (Intermediate Care Facility/Mentally Retarded) and POS 56 (Psychiatric Residential Treatment Center). For further guidance on POS codes and associated CPT codes, refer to Section 30.6.14.

CPT codes 99304–99306 shall be used to report the initial visit. Only a physician may report these codes for an initial visit performed in an SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when state law permits, as explained above).

A readmission to an SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his professional service to the facility.

As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

Medically Necessary Visits
Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare

Evaluation and Management Services

Part B. CPT codes, Subsequent Nursing Facility Care, per day (99307–99310), shall be reported for these E/M visits even if the visits are provided prior to the initial visit by the physician.

SNF Setting – Place of Service Code 31
Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the state and performing within the scope of practice in that state.

NF Setting – Place of Service Code 32
Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the state scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the state, perform the initial visit in an NF and may perform any other federally mandated physician visit in an NF in addition to performing other medically necessary E/M visits. Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate state survey and certification agency departments for clarification.

Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF
Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial visit by the physician, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Subsequent Nursing Facility Care, per day, (99307–99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits. Medicare does not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The nursing facility services codes represent a “per day” service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit.

Other Nursing Facility Service (99318), may be used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. For Medicare Part B payment policy, an annual nursing facility assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a Subsequent Nursing Facility

Evaluation and Management Services

Care, per day, service (codes 99307–99310). It shall not be performed in addition to the required number of federally mandated physician visits.

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial visit by the physician in an SNF.

Qualified NPPs in the NF setting who are not employed by the NF, may perform federally mandated physician visits, at the option of the state, after the initial visit by the physician.

Medicare does not pay for additional E/M visits that may be required by state law for a facility admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any state requirement or administrative purpose) are payable under Medicare Part B.

Visits by Qualified Non-Physician Practitioners
All E/M visits shall be within the state scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the state scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary Visits
Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. CPT codes, Subsequent Nursing Facility Care, per day (99307–99310), shall be reported for these E/M visits even if the visits are provided prior to the initial visit by the physician.

SNF Setting – Place of Service Code 31
Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the state and performing within the scope of practice in that state.

NF Setting – Place of Service Code 32
Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the state scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the state,

Evaluation and Management Services

perform the initial visit in an NF and may perform any other federally mandated physician visit in an NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate state survey and certification agency departments for clarification.

Medically Complex Care
Payment is made for E/M visits to patients in an SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record. Physicians and qualified NPPs shall report initial nursing facility care codes for their first visit with the patient. The principal physician of record must append the modifier AI to the initial nursing facility care code when billed to identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care. Follow-up visits shall be billed subsequent nursing facility care visits.

'Incident to' Services
When a physician establishes an office in an SNF/NF, the "incident to" services and requirements are confined to this discrete part of the facility designated as his office. "Incident to" E/M visits, provided in a facility setting, are not payable under the physician fee schedule for Medicare Part B. Thus, visits performed outside the designated "office" area in the SNF/NF would be subject to the coverage and payment rules applicable to the SNF/NF setting and shall not be reported using the CPT codes for office or other outpatient visits or use POS code 11.

Use of the Prolonged Services Codes and Other Time-Related Services
Beginning January 1, 2008, typical/average time units for E/M visits in the SNF/NF settings are re-established. Medically necessary prolonged services for E/M visits (codes 99356 and 99357) in an SNF or NF may be billed with the Nursing Facility Services in the code ranges (99304–99306, 99307–99310 and 99318).

Counseling and Coordination of Care Visits
With the re-establishment of typical/average time units, medically necessary E/M visits for counseling and coordination of care for Nursing Facility Services in the code ranges (99304–99306, 99307–99310 and 99318) that are time-based services may be billed with the appropriate Prolonged Services codes (99356 and 99357).

Gang Visits
The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient (refer to Section 1862 (a)(1)(A) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits. The E/M visit (Nursing Facility Services) represents a

Evaluation and Management Services

"per day" service per patient as defined by the CPT code. The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.

Split/Shared E/M Visit
A split/shared E/M visit cannot be reported in the SNF/NF setting. A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision-making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to consultation services, critical care services or procedures.

SNF/NF Discharge Day Management Service
Medicare requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. The CPT codes 99315–99316 shall be reported for this visit. The discharge day management service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has died, but only if the physician or qualified NPP personally performed the death pronouncement.

Domiciliary Care Visits

Codes (Refer to the current CPT book for complete CPT code descriptions.)

New Patient

99324–99328

Established Patient

99334–99337

- CPT codes 99324–99337, domiciliary, rest home (e.g., boarding home) or custodial care services, are used to report E/M services to residents residing in a facility that provides room, board and other personal assistance services, generally on a long-term basis. These CPT codes are used to report E/M services in facilities assigned POS codes 13 (Assisted-Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 55 (Residential Substance Abuse

Facility). Assisted-living facilities may also be known as adult living facilities.

- CPT codes 99341–99350, home services codes, are used to report E/M services furnished to a patient residing in his own private residence (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted-living facilities and group homes. The home services codes apply only to the specific two-digit POS 12 (Patient's Home). Home services CPT codes may not be used for billing for E/M services provided in settings other than the private residence of an individual as described above.
- E/M services provided to patients residing in an SNF or an NF must be reported using the appropriate level of service code within the range identified for nursing facility assessments and subsequent nursing facility care services. Use CPT codes 99315–99316 for SNF/NF discharge services. Home services codes should not be used for these places of service.
- The CPT SNF/NF code definition includes Intermediate Care Facilities (ICFs) and Long-Term Care Facilities (LTCFs). These codes are limited to the specific two-digit POS 31 (SNF), 32 (NF), 54 (Intermediate Care Facility/Mentally Retarded) and 56 (Psychiatric Residential Treatment Center).
- The nursing facility codes should be used with POS 31 (SNF) if the patient is in a Part A SNF stay and POS 32 (NF) if the patient does not have Part A SNF benefits. There is no longer a different payment amount for a Part A or Part B benefit period in these POS settings.

Home Services

Codes (Refer to the current CPT book for complete CPT code descriptions.)

New Patient

99341–99345

Established Patient

99347–99350

Requirement for Physician Presence

Home services codes 99341–99350 are paid when they are billed to report E/M services provided in a private residence. A physician cannot bill a home visit unless the physician was actually present in the beneficiary's home.

Homebound Status

Under the home health benefit, the beneficiary must be confined to the home for services to be covered. For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

Evaluation and Management Services

Fee Schedule Payment for Services to Homebound Patient Under General Supervision

Payment may be made in some medically underserved areas when there is a lack of medical personnel and home health services for injections, EKGs and venipunctures performed for homebound patients under general physician supervision by nurses and paramedical employees of physicians or physician-directed clinics.

Prolonged Services and Standby Services (Codes 99354–99360)

Codes (Refer to the current CPT book for complete CPT code descriptions.)

Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354–99357)

Prolonged physician services (CPT code 99354) in the office or other outpatient setting with direct face-to-face patient contact that require one hour beyond the usual service are payable when billed on the same day by the same physician or qualified NPP as the companion E/M codes. The time for usual service refers to the typical/average time units associated with the companion E/M service as noted in the CPT code. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported with CPT code 99355.

Prolonged physician services (code 99356) in the inpatient setting, with direct face-to-face patient contact that require one hour beyond the usual service are payable when they are billed on the same day by the same physician or qualified NPP as the companion E/M codes. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported with CPT code 99357.

Prolonged service of fewer than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

Code 99355 or 99357 may be used to report each additional 30 minutes beyond the first hour of prolonged services based on the place of service. These codes may be used to report the final 15–30 minutes of prolonged service on a given date, if not otherwise billed. Prolonged service of fewer than 15 minutes beyond the first hour or fewer than 15 minutes beyond the final 30 minutes is not reported separately.

Required Companion Codes

Prolonged services codes 99354–99355 are payable when billed on the same day by the same physician as the companion E/M codes.

- The companion E/M codes for 99354 are the office or other outpatient visit codes (99201–99205, 99212–99215), the office or other outpatient consultation codes (99241–99245), the domiciliary, rest home or custodial care services codes (99324–99328, 99334–99337), and the home services codes (99341–99345,

99347–99350).

- The companion codes for 99355 are 99354 and one of the E/M codes required for 99354 to be used.
- The companion E/M codes for 99356 are the initial hospital care codes and subsequent hospital care codes (99221–99223, 99231–99233), the inpatient consultation codes (99251–99255), and nursing facility services codes (99304–99318).

  Or,
- The companion codes for 99357 are 99356 and one of the E/M codes required for 99356 to be used.

Prolonged services codes 99354–99357 are not paid unless they are accompanied by the companion codes as indicated.

Requirement for Physician Presence

Physicians may count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable. In the case of prolonged office services, time spent by office staff with the patient or time the patient remains unaccompanied in the office cannot be billed. In the case of prolonged hospital services, time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, changes in the patient's condition, end of a therapy or use of facilities cannot be billed as prolonged services.

Documentation

Documentation is not required to accompany the bill for prolonged services unless the physician has been selected for medical review. Documentation is required in the medical record about the duration and content of the medically necessary E/M service and prolonged services billed. 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. The start and end times of the visit shall be documented in the medical record along with the date of service.

Use of the Codes

Prolonged services codes can be billed only if the total duration of all physician or qualified NPP direct face-to-face services (including the visit) equals or exceeds the threshold time for the E/M service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes). If the total duration of direct face-to-face time does not equal or exceed the threshold time for the level of E/M service the physician or qualified NPP provided, the physician or qualified

Evaluation and Management Services

NPP may not bill for prolonged services.

Threshold Times for Codes 99354 and 99355 (Office or Other Outpatient Setting)

If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, the physician should bill the E/M visit code and code 99354. No more than one unit of 99354 is acceptable. If the total direct face-to-face time equals or exceeds the threshold time for code 99355 by no more than 29 minutes, the physician should bill the visit code 99354 and one unit of code 99355. One additional unit of code 99355 should be billed for each additional increment of 30 minutes extended duration.

The following threshold times are used to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings including domiciliary, rest home or custodial care services, and home services codes.

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99324	20	50	95
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100

Evaluation and Management Services

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99349	40	70	115
99350	60	90	135

Add 30 minutes to the threshold time for billing codes 99354 and 99355 to get the threshold time for billing code 99354 and two units of code 99355. For example, to bill code 99354 and two units of code 99355 when billing code 99205, the threshold time is 150 minutes.

Threshold Times for Codes 99356 and 99357 (Inpatient Setting)

If the total direct face-to-face time equals or exceeds the threshold time for code 99356, but is less than the threshold time for code 99357, the physician should bill the visit and code 99356. No more than one unit of code 99356 is acceptable. If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, the physician should bill visit code 99356 and one unit of code 99357. One additional unit of code 99357 should be billed for each additional increment of 30 minutes' extended duration.

The following threshold times are used to determine if the prolonged services codes 99356 and/or 99357 can be billed with the inpatient setting codes.

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99304	25	55	100
99305	35	65	110
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105

Evaluation and Management Services

Add 30 minutes to the threshold time for billing codes 99356 and 99357 to get the threshold time for billing code 99356 and two units of 99357.

Prolonged Services Associated With E/M Services Based on Counseling and/or Coordination of Care (Time-Based)

When an E/M service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50 percent of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the E/M code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the E/M code) and should not be "rounded" to the next higher level.

In those E/M services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

Examples of Billable Prolonged Services

Example 1: A physician performed a visit that met the definition of an office visit code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills code 99213 and one unit of code 99354.

Example 2: A physician performed a visit that met the definition of a domiciliary, rest home care visit code 99327 and the total duration of the direct face-to-face contact (including the visit) was 140 minutes. The physician bills codes 99327, 99354 and one unit of code 99355.

Example 3: A physician performed an office visit to an established patient that was predominantly counseling, spending 75 minutes (direct face-to-face) with the patient. The physician should report CPT code 99215 and one unit of code 99354.

Examples of Non-Billable Prolonged Services

Example 1: A physician performed a visit that met the definition of visit code 99212 and the total duration of the direct face-to-face contact (including the visit) was 35 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

Example 2: A physician performed a visit that met the definition of code 99213 and while the patient was in the office receiving treatment for four hours, the total duration of the direct face-to-face service of the physician was 40

minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

Example 3: A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot bill code 99214, which has a typical time of 25 minutes and one unit of code 99354. The physician must bill the highest level code in the code family (99215, which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

Prolonged Services Without Direct Face-to-Face Patient Contact Service (Codes 99358–99359)

Medicare does not cover prolonged services codes 99358 and 99359, which do not require any direct patient face-to-face contact (e.g., telephone calls). Payment for these services is included in the payment for direct face-to-face services that physicians bill. The physician cannot bill the patient for these services since they are Medicare-covered services and payment is included in the payment for other billable services.

Physician Standby Service (Code 99360)

Standby services are not payable to physicians. Physicians may not bill Medicare or beneficiaries for standby services. Payment for standby services is included in the Part A payment to the facility. Such services are a part of hospital costs to provide quality care. If hospitals pay physicians for standby services, such services are part of hospital costs to provide quality care.

Case Management

Physician case management is a process in which a physician is responsible for direct care of a patient and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

Team Conferences

These services are considered bundled and are never paid separately:

- 99366.
- 99367.
- 99368.

Telephone Calls

These services are considered non-covered services:

- 99441.

Evaluation and Management Services

- 99442.
- 99443.

Screening and Preventive Services

For complete coverage and billing guidelines, please refer to the *Screening and Preventive Services* manual. This manual can be downloaded from the TrailBlazer Web site at:

http://www.trailblazerhealth.com/Publications/Training Manual/screening.pdf

Additionally, the Preventive Services Web page on the TrailBlazer Web site contains helpful links and other information:

http://www.trailblazerhealth.com/Specialty Services/Preventive Services/default.aspx

Primary Care Incentive Payment Program (PCIP)

The following information is excerpted from the Medicare Learning Network (MLN) Matters® article MM7060.

For primary care services furnished on or after January 1, 2011, and before January 1, 2016, a 10 percent incentive payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of non-physician practitioners, enrolled in Medicare with a primary care specialty designation of 50-Nurse Practitioner, 89-certified Clinical Nurse Specialist, or 97-Physician Assistant.

CPT Codes	Description
99201	Level 1 new patient office or other outpatient visit
99202	Level 2 new patient office or other outpatient visit
99203	Level 3 new patient office or other outpatient visit
99204	Level 4 new patient office or other outpatient visit
99205	Level 5 new patient office or other outpatient visit
99211	Level 1 established patient office or other outpatient visit
99212	Level 2 established patient office or other outpatient visit
99213	Level 3 established patient office or other outpatient visit
99214	Level 4 established patient office or other outpatient visit

Evaluation and Management Services

CPT Codes	Description
99215	Level 5 established patient office or other outpatient visit
99304	Level 1 initial nursing facility care
99305	Level 2 initial nursing facility care
99306	Level 3 initial nursing facility care
99307	Level 1 subsequent nursing facility care
99308	Level 2 subsequent nursing facility care
99309	Level 3 subsequent nursing facility care
99310	Level 4 subsequent nursing facility care
99315	Nursing facility discharge day management; 30 minutes
99316	Nursing facility discharge day management; more than 30 minutes
99318	Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment
99324	Level 1 new patient domiciliary, rest home, or custodial care visit
99325	Level 2 new patient domiciliary, rest home, or custodial care visit
99326	Level 3 new patient domiciliary, rest home, or custodial care visit
99327	Level 4 new patient domiciliary, rest home, or custodial care visit
99328	Level 5 new patient domiciliary, rest home, or custodial care visit
99334	Level 1 established patient domiciliary, rest home, or custodial care visit
99335	Level 2 established patient domiciliary, rest home, or custodial care visit
99336	Level 3 established patient domiciliary, rest home, or custodial care visit
99337	Level 4 established patient domiciliary, rest home, or custodial care visit
99339	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes
99340	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more
99341	Level 1 new patient home visit
99342	Level 2 new patient home visit
99343	Level 3 new patient home visit
99344	Level 4 new patient home visit
99345	Level 5 new patient home visit
99347	Level 1 established patient home visit
99348	Level 2 established patient home visit
99349	Level 3 established patient home visit

Evaluation and Management Services

CPT Codes	Description
99350	Level 4 established patient home visit

Eligible practitioners would be identified on a claim based on the NPI of the rendering practitioner. If the claim is submitted by a practitioner or group practice, the rendering practitioner's NPI must be included on the line-item for the primary care service (identified in the above table) in order for a determination to be made regarding whether or not the service is eligible for payment under the PCIP. In order to be eligible for the PCIP, Physician Assistants, Clinical Nurse Specialists, and Nurse Practitioners must be billing for their services under their own NPI and not furnishing services incident to physicians' services. Regardless of the specialty area in which they may be practicing, these specific non-physician practitioners are eligible for the PCIP based on their profession and historical percentage of allowed charges as primary care services that equals or exceeds the 60 percent threshold.

Beginning in CY 2011, primary care practitioners will be identified based on their primary specialty of enrollment in Medicare and percentage of allowed charges for primary care services that equals or exceeds the 60 percent threshold from Medicare claims data 2 years prior to the bonus payment year. A provision to accommodate newly enrolled Medicare providers will be released in 2011.

Coordination with Other Payments

Section 5501(a)(3) of The Affordable Care Act provides payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under section 1833(m) of The Social Security Act. Therefore, an eligible primary care physician furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011.

For additional information, MM7060, titled "Incentive Payment Program for Primary Care Services, Section 5501(a) of the Affordable Care Act," is available on the CMS MLN Matters® Web page.

http://www.cms.gov/MLNMattersArticles/downloads/MM7060.pdf

SMOKING AND TOBACCO-USE CESSATION COUNSELING

Medicare covers two new levels of counseling, intermediate and intensive, for smoking and tobacco-use cessation, effective March 22, 2005. The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use as based on Food and Drug Administration (FDA)-approved information.

What Is Covered?

Smoking and tobacco cessation counseling is covered under Medicare Part B. Patients must be competent and alert at the time services are provided. Two attempts are covered each year and each attempt may include a maximum of four intermediate or intensive cessation strategies for each session. A maximum of eight sessions in a 12-month period are covered.

Billing Codes

For dates of service on or after January 1, 2008, use the following codes.

99406©	Smoking and tobacco-use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes
99407©	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

Diagnosis Codes

Smoking and tobacco-use cessation counseling claims should be submitted with the appropriate diagnosis code. Diagnosis codes should reflect the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent and whose metabolism is affected by the use of tobacco.

Documentation

Providers should keep appropriate documentation in the patient's medical records to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco-use cessation counseling.

E/M Services

Physicians and other Medicare-recognized practitioners who need to bill for E/M services on the same day as smoking cessation services should use the appropriate E/M CPT code in the 99201–99215 range and modifier 25 to show the E/M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

Evaluation and Management Services

Inpatient Hospital

Medicare will not cover tobacco cessation services for patients in an inpatient hospital stay if tobacco cessation is the primary reason for the inpatient stay.

Common Working File (CWF) Inquiry Screens

Providers who have access to Common Working File (CWF) inquiry screens will be able to view the number of smoking and tobacco-use cessation counseling sessions provided to a beneficiary. Providers will be able to access this file through the CWF by entering the beneficiary's Health Insurance Claim Number (HICN).

HOSPICE

Overview

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare-certified hospice is covered under the hospice benefit provisions.

Independent Attending Physician Services

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his terminal illness during the period his hospice benefit election is in force, except for professional services of an independent attending physician who is not an employee of the designated hospice and does not receive compensation from the hospice for those services.

For purposes of administering the hospice benefit provisions, an "attending physician" means an individual who:

- Is a doctor of medicine or osteopathy.

  Or,
- Is a nurse practitioner.

  And,
- Is identified by the individual at the time he elects hospice coverage as having the most significant role in the determination and delivery of his medical care.

Hospices should reiterate with patients that they must not see independent physicians for care related to their terminal illness other than their independent attending physician unless the hospice arranges it.

The beneficiary may designate and use an independent attending physician/nurse practitioner who is not employed by and does not receive compensation from the hospice for professional services furnished in addition to the services of hospice-employed physicians.

The physician or other provider must look to the hospice for payment when the service is considered a hospice service (a service related to the patient's terminal illness that was furnished by someone other than the designated attending physician).

Services provided by an independent attending physician/nurse practitioner must be coordinated with any direct care services provided by the hospice physicians.

Evaluation and Management Services

Test Components

Professional services related to the hospice patient's terminal condition furnished by the "attending physician" should be billed to Medicare. When the attending physician furnishes a terminal illness-related service that includes both a professional and technical component (e.g., X-rays), only the professional component of the service should be billed to Medicare. The hospice is responsible for payment of the technical component.

Services Unrelated to the Terminal Illness

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected and that are furnished during a hospice election period may be billed to Medicare by the rendering provider.

Modifiers

GV **Attending physician not employed or paid under agreement by the patient's hospice provider**

Professional services of a non-hospice-affiliated attending physician for the treatment and management of a hospice patient's terminal illness are not considered "hospice services." These attending physician services are billed to the carrier, provided they were not furnished under a payment arrangement with the hospice. Bill the services with the GV modifier.

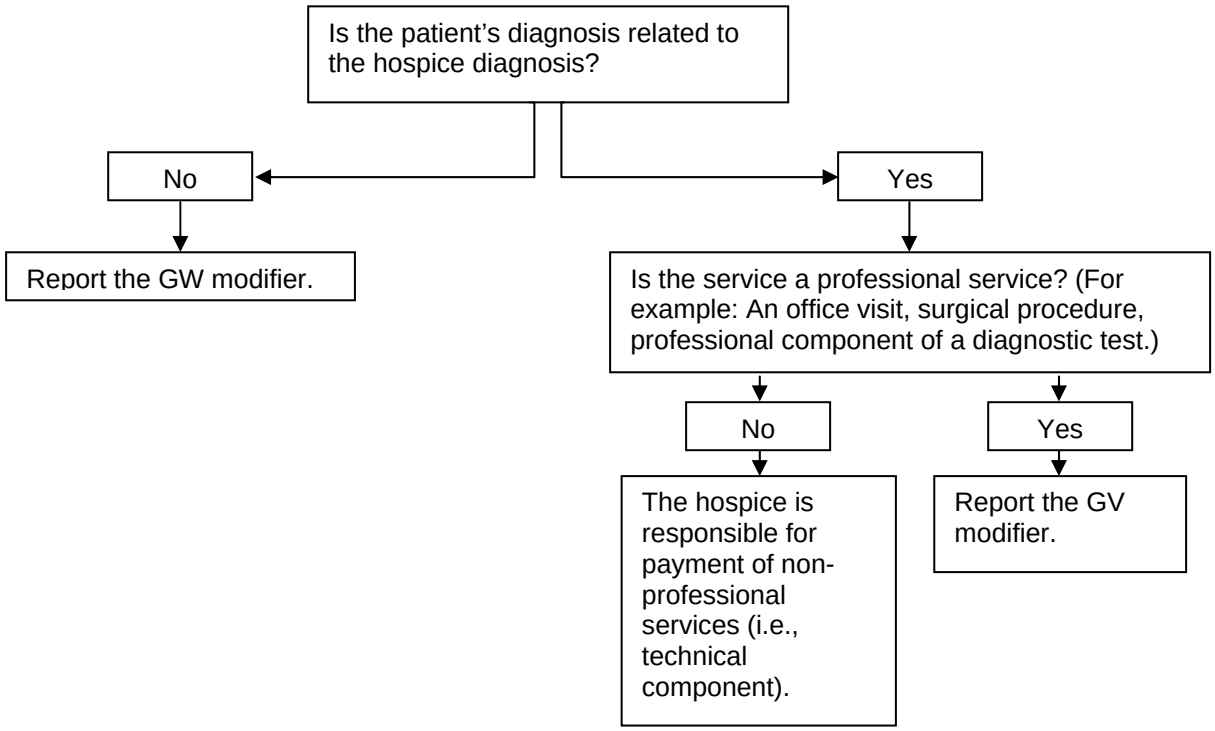
GW **Service not related to the hospice patient's terminal illness**

Services unrelated to the hospice patient's terminal illness should be billed with the GW modifier.

Evaluation and Management Services

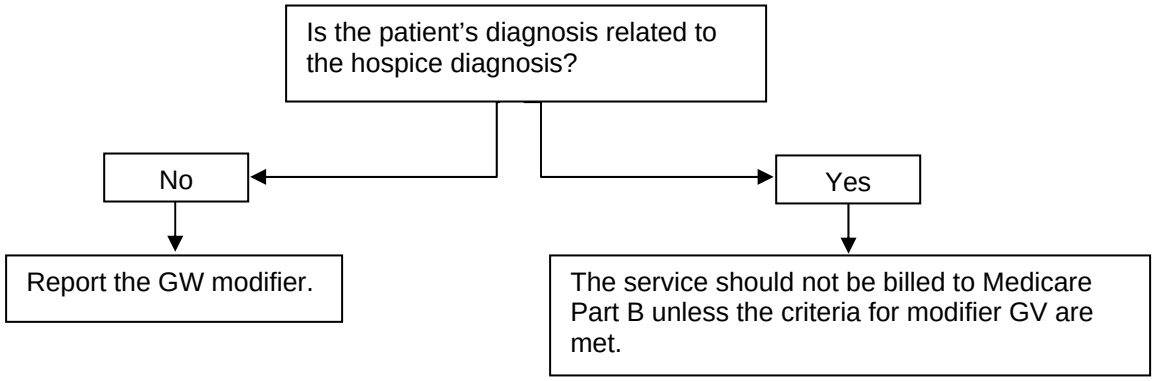
When to Bill Hospice Modifiers GV and GW

The Physician *Is* the Attending Physician



Evaluation and Management Services

All Providers



For additional assistance in choosing modifier GV or GW, see the hospice decision tree at:

http://www.trailblazerhealth.com/Customer Service/Self-Service Tools/HospiceIDT.aspx

Locum Tenens/Reciprocal Billing

If another physician covers for a hospice patient's designated attending physician, the services of the substituting physician should be billed by the designated attending physician under the reciprocal or locum tenens billing instructions. In such instances, the attending physician should bill using the GV modifier in conjunction with the Q5 or Q6 modifier.

Claims From Medicare Advantage (MA) Plans

Medicare physicians may bill Medicare contractors for non-hospice services provided to Medicare Advantage (MA) plan enrollees who elect hospice benefits. These claims should be submitted with a GV or GW modifier as applicable.

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition, or an MA plan to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

- Hospice services covered under the Medicare hospice benefit if billed by a Medicare provider.
- Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice.
- Services not related to the treatment of the terminal condition while the beneficiary has elected hospice.
- Services furnished after the revocation or expiration of the enrollee's hospice

election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked his hospice election.

CARE PLAN OVERSIGHT (CPO) SERVICES

CPO services are covered once per calendar month.

CPO is the supervision of a patient under the care of a Home Health Agency (HHA) or hospice who requires complex and multidisciplinary care modalities involving any of the following:

- Regular physician development and/or revision of care plans.
- Review of subsequent reports of patient status.
- Review of related laboratory and other studies.
- Communication with other health professionals not employed in the same practice who are involved in the patient's care.
- Integration of new information into the care plan.
- Adjustment of medical therapy.

Such services are covered for home health and hospice patients, but are not covered for patients of Skilled Nursing Facilities (SNFs), nursing home facilities or inpatient hospitals.

Non-Physician Practitioners (NPPs)

Nurse practitioners, physician assistants and clinical nurse specialists practicing within the scope of state law may bill for CPO. Non-Physician Practitioners (NPPs) must be providing ongoing care for the beneficiary through Evaluation and Management (E/M) services (but not if they are involved only in the delivery of the Medicare-covered home health or hospice service).

Home Health CPO

NPPs can perform CPO only if the physician signing the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for CPO and either:

- The physician and NPP are part of the same group practice.
- If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP.
- If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.

Providers may bill for CPO furnished by an NPP when:

- The NPP providing the CPO has seen and examined the patient.
- The NPP providing CPO is not functioning as a consultant whose participation is limited to a single medical condition rather than multidisciplinary coordination of care.

Evaluation and Management Services

- The NPP providing CPO integrates his care with that of the physician who signed the plan of care.

NPPs may not certify the beneficiary for home health care.

Hospice CPO

The attending physician or nurse practitioner (who has been designated as the attending physician) may bill for hospice CPO when they are acting as an "attending physician." An "attending physician" is one who has been identified by the individual at the time he elects hospice coverage as having the most significant role in the determination and delivery of his medical care. He is not employed or paid by the hospice. Bill CPO services using Form CMS-1500 or electronic equivalent.

Conditions for Coverage

These services are covered only once per calendar month if all of the following requirements are met:

- The beneficiary must require complex or multidisciplinary care modalities requiring ongoing physician involvement in the patient's plan of care.
- The CPO services should be furnished during the period in which the beneficiary was receiving Medicare-covered HHA or hospice services.
- The physician who bills CPO must be the same physician who signed the home health or hospice plan of care (refer to information under "Non-Physician Practitioners" if provided by an NPP).
- The physician furnished at least 30 minutes of CPO within the calendar month for which payment is claimed, provided no other physician has been paid for CPO within the calendar month.
- The physician provided a covered physician service that required a face-to-face encounter with the beneficiary within the six months immediately preceding the first CPO service. Only E/M services are acceptable as prerequisite face-to-face encounters for CPO. EKG, lab and surgical services are not sufficient face-to-face services for CPO.
- The CPO billed by the physician was not routine postoperative care provided in the global surgical period of a surgical procedure billed by the physician.
- If the beneficiary is receiving HHA services, the physician did not have a significant financial or contractual interest in the HHA. A physician who is an employee of a hospice, including a volunteer medical director, should not bill CPO services. Payment for the services of a physician employed by the hospice is included in the payment to the hospice.
- The physician who bills the CPO services is the physician who furnished them.
- Services provided "incident to" a physician's service do not qualify as CPO and do not count toward the 30-minute requirement.

Evaluation and Management Services

- The physician is not billing for the Medicare End Stage Renal Disease (ESRD) capitation payment for the same beneficiary during the same month.
- The physician billing for CPO must document in the patient's record the services furnished and the date and length of time associated with those services.

Which Services Count Toward the 30 Minutes?

- Review of charts, reports, treatment plans or lab or study results, except for the initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
- Telephone calls with other health care professionals (not employed in the same practice) involved in the care of the patient.
- Team conferences (time spent per individual patient must be documented).
- Telephone or face-to-face discussions with a pharmacist about pharmaceutical therapies.
- Medical decision-making.
- Activities to coordinate services are countable if the coordination activities require the skills of a physician.

Which Services Do Not Count Toward the 30 Minutes?

Services not countable toward the 30-minute threshold that must be provided to bill for CPO include, but are not limited to:

- Time associated with discussions with the patient, his family or friends to adjust medication or treatment.
- Physician's time spent telephoning prescriptions to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.
- Time spent by staff getting or filing charts.
- Travel time.
- Initial interpretation or review of lab or study results that were ordered during or are associated with a face-to-face encounter.
- Low-intensity services included as part of other E/M services.
- Informal consults with health professionals not involved in the patient's care.
- The physician's time spent discussing with his nurse conversations the nurse had with the HHA. However, time spent by the physician working on the care plan after the nurse has conveyed the pertinent information to the physician is countable toward the 30 minutes.
- The work included in hospital discharge day management (codes 99238–99239) and discharge from observation (code 99217) is not countable toward the 30 minutes per month required for work on the same day as discharge but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital.

Evaluation and Management Services

Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the HHA or hospice during the month for which CPO services were billed.

CPO Billing Requirements

G0181 Physician supervision of a patient receiving Medicare-covered services provided by a participating HHA (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into medical treatment plan, and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

G0182 Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into medical treatment plan, and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

- No other services may be submitted on the claim with CPO services.
- These services are covered only once per calendar month after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months and should be submitted (and paid) only for one unit of service.

PHYSICIAN SERVICES FOR CERTIFICATION AND RECERTIFICATION OF MEDICARE-COVERED HOME HEALTH SERVICES

Physician services involved in physician certification (and recertification) of Medicare-covered home health services may be separately coded and reimbursed. These services include creation and review of a plan of care and verification that the Home Health Agency (HHA) initially complies with the physician's plan of care. The physician's work in reviewing data collected in the HHA's patient assessment would be included in these services. This article defines coverage for the physician service. For information concerning coverage of home health services, please refer to the *Home Health Agency Manual* and the appropriate home health intermediary.

Medicare-covered home health services are defined in the *Home Health Agency Manual,* Section 203:

http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021914

The physician may bill physician certification for a patient receiving Medicare-covered home health services that require the development of a plan of care. The physician must participate in the development of the plan of care and review of data collected in the HHA's patient assessment in addition to signing the certification statement.

CPT/HCPCS Codes

G0179	MD recertification HHA PT
G0180	MD certification HHA patient

Coding Guidelines

- Use HCPCS code G0180 to bill physician services for initial certification of Medicare-covered HHA services.
- Use HCPCS code G0179 to bill physician services for recertification of Medicare-covered HHA services.
- Enter "1" as the number of services in Item 24 of the CMS-1500 claim form or, if submitting electronically, in the ANSI format: 2400/SV104 (UN qualifier).
- The place of service code should represent the place where the preponderance of the plan development and review work was performed. This place of service code should be consistent with the policies enumerated above. Appropriate place of service codes are limited to: 11 (Office), 12 (Home), 22 (Outpatient Hospital) and 71 (State/Local Public Health Clinic).
- No other services may be billed on the same claim as the physician services for certification or recertification.

Evaluation and Management Services

Counting 60-Day Episodes of Certification and Recertification of Home Health Services

The home health agency certification code can be billed only when the patient has not received Medicare-covered home health services for at least 60 days. The home health agency recertification code is used after a patient has received services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period. The home health agency recertification code will be reported only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapse and requires a new plan of care to start a new episode.

Counting Initial Episodes

The "from" date for the initial certification must match the Start of Care (SOC) date, which is the first billable visit date for the 60-day episode. The "to" date is up to and including the last day of the episode, which is not the first day of the subsequent episode. The "to" date can be up to but never exceed a total of 60 days, which includes the SOC date plus 59 days.

Counting Subsequent Episodes

If a patient continues to be eligible for the home health benefit, the home health Prospective Payment System (PPS) permits continuous episode recertifications. At the end of the 60-day episode, a decision must be made whether to recertify the patient for a subsequent 60-day episode. An eligible beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. The "from" date for the first subsequent episode is day 61 up to and including day 120. The "to" date for the subsequent episode in this example can be up to but never exceed a total of 60 days, which includes day 61 plus 59 days.

Note that the certification or recertification visit can be done during a prior episode.

Example:

The first 60-day episode ended on June 1. A new episode will begin on June 2 (on the 61st day) and continue through July 31. The next episode can start on August 1, which is the 61st day.

Reference: Medicare Benefit Policy Manual, IOM Pub. 100-02, Chapter 7, Section 10.4

The G0179 Frequency Calculator may be used to determine when the next recertification code G0179 may be billed:

http://www.trailblazerhealth.com/Tools/FrequencyCalculator_G0179.aspx

CLINICAL DIAGNOSTIC LABORATORY SERVICES

Laboratory and pathology CPT coding includes services primarily reported to evaluate specimens obtained from patients (body fluids, cytological specimens or tissue specimens obtained by invasive/surgical procedures) to provide information to the treating physician. This information, coupled with information obtained from history and examination finds and other data, provides the physician with the background upon which medical decision-making is established.

Clinical laboratory services must be ordered and used promptly by the physician who is treating the beneficiary as described in 42 CFR 410.32(a) or by a qualified non-physician practitioner as described in 42 CFR 410.32(a)(3).

For more information on documentation requirements for physicians ordering lab services, see the *Laboratory and Pathology* manual at:

http://www.trailblazerhealth.com/Publications/Training Manual/Lab-Path.pdf

DRUGS AND INJECTIONS

The TrailBlazer Web site contains complete information about drugs and biologicals coverage, guidelines and pricing. The site also includes the drug fee schedule:

http://www.trailblazerhealth.com/Payment/Fee Schedules

Drugs and Biologicals Fee Schedule

Per the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, CMS will supply Medicare contractors with an Average Sales Price (ASP) drug-pricing file for paying drugs. Payment will be based on the lower of the submitted charge or the ASP price. Payment will continue to be based on the date of service. The fee schedule contains pricing for drugs and biologicals that have been assigned HCPCS codes. For non-classified drugs and biologicals, please see the Not Otherwise Classified (NOC) Drug Fee Schedule for the date of service for the time period the service was performed.

The drug fee schedule may be accessed through the link above.

Mandatory Assignment

Under Section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA), payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Medicare Part B deductible and coinsurance amounts.

NOC Drugs

Report NOC drugs using the appropriate NOC code.

When submitting a claim for an NOC drug code, enter the name of the drug and the total dosage administered in Item 19 of the CMS-1500 claim form or the Notes field if submitting electronically.

COMPETITIVE ACQUISITION PROGRAM (CAP) FOR PART B DRUGS

Background

Section 303(d) of the Medicare Prescription Improvement and Modernization Act (MMA) of 2003 requires the implementation of a Competitive Acquisition Program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians are given a choice between buying and billing these drugs under the Average Sales Price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. For purposes of the CAP, the term "physician" includes individuals defined under Section 1861(s) of the Social Security Act (the Act) who are authorized to provide physician services under Section 1861(s) of the Act and who can, within their state's scope of practice, prescribe and order drugs covered under Medicare Part B.

CMS Web Site

Refer to the CMS Web site for the most complete and up-to-date CAP information.

http://www.cms.gov/CompetitiveAcquisforBios/

CAP Is Postponed for 2009

Earlier this year, CMS accepted bids for vendor contracts for the 2009-2011 CAP. While CMS received several qualified bids, contractual issues with the successful bidders resulted in CMS postponing the 2009 program. As a result, CAP drugs will not be available from an approved CAP vendor for dates of service after December 31, 2008, and the 2009 CAP physician election period scheduled for October 1 to November 15, 2008, will not be held. CAP drugs will not be available from an approved CAP vendor for dates of service after December 31, 2008.

Drug Ordering

The contract with the current approved CAP vendor, BioScrip Inc., will remain in effect through December 31, 2008. Participating CAP physicians must continue to obtain CAP drugs from the approved CAP vendor if the drugs are to be administered on or before December 31, 2008. After January 1, 2009, physicians must obtain and bill for drugs through the ASP process, and physicians will also be responsible for collecting applicable deductible and coinsurance from Medicare beneficiaries. Physicians should be mindful of the anticipated date of a CAP drug's administration when ordering drugs for administration in December 2008.

Unused CAP drugs that remain at a physician's office belong to the approved CAP vendor. They may be returned to the approved CAP vendor, if permissible by state law, or purchased from the approved CAP vendor for administration under the ASP methodology for dates of service after January 1, 2009. Unused CAP drugs cannot be

given away to a physician. Participating CAP physicians should contact the approved CAP vendor as early as possible to determine whether buying or returning unused drugs is preferable, and take steps to minimize the amount of unused drugs at their offices.

Claims Processing and Billing

Participating CAP physicians must submit CAP claims to their local carrier or Medicare Administrative Contractor (MAC) within 30 days of CAP drug administration. After January 1, 2009, participating CAP physicians can continue to submit CAP claims for dates of service through December 31, 2008.

Drugs acquired through ASP for administration on or after January 1, 2009, must be billed through ASP, and physicians should not use any of the CAP modifiers (J1, J2, J3, M2) in these claims.

TREATMENT OF OBESITY

Obesity may be caused by medical conditions such as hypothyroidism, Cushing's disease, and hypothalamic lesions or can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension. Non-surgical services in connection with the treatment of obesity are covered when such services are an integral and necessary part of a course of treatment for one of these medical conditions. Certain designated surgical services for the treatment of obesity are covered for Medicare beneficiaries who have a Body Mass Index (BMI) >35, have at least one comorbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity.

In addition, supplemented fasting is a type of very low-calorie weight reduction regimen used to achieve rapid weight loss. The reduced calorie intake is supplemented by a mixture of protein, carbohydrates, vitamins and minerals. Serious questions exist about the safety of prolonged adherence for two months or more to a very low-calorie weight reduction regimen as a general treatment for obesity because of instances of cardiopathology and sudden death, as well as possible loss of body protein.

Nationally Covered Indications

Certain designated surgical services for the treatment of obesity are covered for Medicare beneficiaries who have a BMI >35, have at least one comorbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity.

Nationally Non-Covered Indications

Treatments for obesity alone remain non-covered. Supplemented fasting is not covered under the Medicare program as a general treatment for obesity.

See IOM Publication 100-03, Chapter 1, Section 40.5.

POWER MOBILITY DEVICE (PMD)

Rules for Adjudicating Claims for PMDs

Physicians should be aware of the critical role they play in prescribing power wheelchairs. Specifically, physicians evaluate a patient's medical conditions and need for mobility, and therefore are the primary gatekeepers of the information CMS uses to base decisions for payment.

To this end, physicians should be conscientious when documenting patient encounters and pay particular attention to describing the patient's clinical condition (e.g., medical history, disease progression, changes in health status), as well as their need for mobility, their living situation (e.g., family support and caregivers), and other treatments that have been tried and considered. Contractors use all this information when evaluating a claim for payment.

Face-to-Face Examination and Prescription

A condition for payment for motorized or power wheelchairs is that the PMD must be prescribed by a physician or treating practitioner (a Physician Assistant (PA), Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) who has conducted a face-to-face examination of the beneficiary and has written a prescription for the PMD. The face-to-face examination requirement does not apply when only accessories for PMDs are being ordered.

The written prescription (order) must include:

- Beneficiary's name.
- Date of the face-to-face examination.
- Diagnoses and conditions that the PMD is expected to modify.
- Description of the item.
- How long it is needed.
- The physician or treating practitioner's signature.
- The date the prescription is written.

The prescription (order) must be:

- In writing.
- Signed and dated by the physician or treating practitioner (a PA, NP or CNS) who performed the face-to-face examination.
- Received by the supplier within 45 days of the face-to-face examination.

The physician or treating practitioner must submit a written prescription (order) for the PMD to the supplier. The supplier must receive this prescription within 45 days of the

face-to-face evaluation, or, in the case of a recently hospitalized beneficiary, within 45 days of the date of discharge from the hospital.

Additional Documentation

The physician or treating practitioner must also provide the supplier with additional documentation describing how the patient meets the clinical criteria for coverage as described in the National Coverage Determination (NCD).

Pertinent parts from the documentation of the beneficiary's PMD evaluation may include the history, physical examination, diagnostic tests, summary of findings, diagnoses and treatment plans. The physician or treating practitioner should select only those parts of the medical record that clearly demonstrate medically necessity for the PMD. The parts of the medical record selected should be sufficient to delineate the history of events that led to the request for the PMD; identify the mobility deficits to be corrected by the PMD; and document that other treatments do not obviate the need for the PMD, that the beneficiary lives in an environment that supports the use of the PMD, and that the beneficiary or caregiver is capable of operating the PMD. In most cases, the information recorded at the face-to-face examination will be sufficient. However, there may be some cases where the physician or treating practitioner has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record. In this instance, those previous notes would also be needed. The physician, treating practitioner or supplier should make sure to remove or edit any materials that may be contained within the medical record that are not necessary to support the order. For example, a gynecologic report would not be needed in the records submitted for a beneficiary whose clinical need for a PMD is based solely on disability secondary to a stroke.

Durable Medical Equipment (DME) suppliers should retain on file the prescription (written order), signed and dated by the treating physician/practitioner, along with the supporting documentation that supports the PMD as reasonable and necessary.

Coding and Billing

Payment for the history and physical examination will be made through the appropriate Evaluation and Management (E/M) code corresponding to the history and physical examination of the patient. Due to the requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the DME supplier, code G0372 was established to recognize additional physician services and resources required to establish and document the need for the PMD.

Code G0372 indicates that:

- All of the information necessary to document the PMD prescription is included in the medical record.

Evaluation and Management Services

- The prescription, along with the supporting documentation, has been delivered to the PMD supplier within 45 days of the face-to-face examination.

The E/M service and G0372 must be billed on the same claim.

Additional Information

For full details regarding wheelchair coverage, visit the CMS page for wheelchairs on the CMS Web site at:

http://www.cms.gov/CoverageGenInfo/06_wheelchair.asp

Physicians, treating practitioners and suppliers should contact the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for coverage instructions related to specific items.

The CMS NCD is located at:

http://www.cms.gov/center/coverage.asp

PHYSICIAN QUALITY REPORTING *SYSTEM (PHYSICIAN QUALITY REPORTING)*

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting *System (Physician Quality Reporting).*

Physician Quality Reporting establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program.

Complete information about this program is available on the CMS Web site and the TrailBlazer Web site at:

- CMS:
  http://www.cms.gov/PQRI/
- TrailBlazer:
  http://www.trailblazerhealth.com/Publications/Training Manual/PQRI.pdf

REVISION HISTORY

Date	Section	Description
August 2009		The name of the *Primary Care* manual has changed to *Evaluation and Management Services* to clarify the contents.
	E/M Services	• Added signature requirements. IOM 100-08, Chapter 3, Section 3.4.1.1B. • Added requirements that certain laboratory services be ordered by the treating physician. IOM 100-08, Chapter 3, Section 3.4.1.1D • Added note, a consultation cannot be performed as a split/shared E/M visit. • IOM 100-04, Chapter 12, Section 30.6.10. Added physician standby services. • IOM 100-04, Chapter 12, Section 30.6.15.3. • Added new Web link for Educational Tips.
	Hospice	Added flow chart for appropriate use of the GV and GW modifiers.
	Physician Services for Certification and Recertification of Medicare Covered Home Health Services	Added Web link for the *Home Health Agency Manual*.
	Hospice	Added additional information on claims from M+C organizations. IOM 100-04, Chapter 11, Section 40.2.2.
	Clinical Diagnostic Laboratory Services	Removed section. Referred to the Web link for the *Laboratory and Pathology* manual.
	Power Mobility Device	Added additional documentation guidelines, additional coding and billing guidelines. IOM 100-08, Chapter 5, Section 5.9.2 and IOM 100-04, Chapter 12, Section 30.6.15.4.

Evaluation and Management Services

Date	Section	Description
	PQRI	Added Web link for *Physician Quality Reporting Initiative (PQRI)* manual.
January 2010	E/M Services	• Added MLN Matters® reference for the deletion of consultation codes effective January 1, 2010 (CR 6740). • Added the AI modifier per CR 6740 effective January 1, 2010.
	Hospice	• Updated the flow chart for hospice modifier GW. • Replaced Medicare+Choice with Medicare Advantage.
February 2010	E/M Services	• Added acceptable and unacceptable documentation signatures. • Updated consultation services, hospital observation services, payment for inpatient hospital visits, emergency department visits, prolonged services and nursing facility services per CR 6740. • Added Web link for the 2010 Consultation Reference Guide.
	Hospice	Updated hospice services.
April 2010	Hospice	Revised the hospice chart.
	All sections	Updated CMS Web site addresses.
December 2010	*E/M Services*	• *Added PCIP, CR 7060.* • *Added scribed services.* • *Added skilled nursing facility and nursing facility reporting of physician consultation services per JSM 11080, December 3, 2010.*
	Hospice	*Added Web link for the hospice decision tree.*
	Physician Services for Certification and Recertification of Medicare-Covered Home Health Services	*Added guidelines for counting episodes of certification and recertification.*
	Treatment of Obesity	*Updated section per IOM.*

Evaluation and Management Services

Date	Section	Description
	All sections	*Changed PQRI to new name – Physician Quality Reporting System.*