

Jurisdiction 1 Part B

Evaluation and Management (E/M) Coding Reminder

This E/M article shares helpful hints when submitting services to J1 Part B for processing. For regulations regarding Physician/NonPhysicians Practitioners Billing, please refer to Chapter 12 of the Centers for Medicare and Medicaid Services (CMS) Internet Online Manual at www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf.

Medical Necessity Determines Payment

Medical necessity of a service is the overarching criterion for payment. Do not submit a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which the service is submitted. Select the code for the service based upon the content of the service. The service furnished and submitted must meet the definition of the code.

Payment of Initial Preventive Physical Examination

Medicare will pay only for one initial preventive physical examination (HCPCS Code G0402) when it occurs within the 12 month period of his/her effective date of the initial enrollment in Medicare Part B.

Documentation Guidelines for All E/M Services

For all E/M services, the 1995 or 1997 E/M documentation guidelines at www.cms.hhs.gov/medlearn/emdoc.asp should be followed when recording the appropriate clinical information in the beneficiary's medical record.

Combined Billing

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were 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. 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.

Two office visits submitted for the same beneficiary, same physician/same specialty in same group, on the same day are not payable. This carrier will deny second visit submitted. This applies to CPT Codes 99201-99215. A review would be necessary for this carrier to consider a second office visit on the same date of service. On review, the provider must clearly indicate the visits were for unrelated problems in the office/outpatient setting which could not have been provided during the same encounter.

E/M services provided on the same day in sites other than the nursing facility will be bundled into the initial nursing facility care code. Hospital and observation services are not included

Observation Care Code

An initial observation care code (CPT codes 99218-99220) is for all the care rendered by the admitting physician on the date the patient was admitted to observation status

When a patient is discharged from observation care on the same date as admission to observation care, provider must use CPT codes 99234-99236, which are observation/inpatient hospital care codes involving the e/m of a patient including admission and discharge on the same date.

When a patient remains in observation status after the first date following the admission to observation, it is expected the patient would be discharged on that second calendar day. The physician should submit CPT code 99217 for observation discharge services provided on the second date. If patient is admitted from observation to initial inpatient status, do not submit CPT Code 99217.

When a patient is admitted as an inpatient from observation status, the initial hospital visit (CPT Codes 99221-99223) is only service payable for that date by same physician/same specialty in same group

Hospital Care Code

The initial hospital care code is the only service payable when submitted on the same day as a nursing facility visit, emergency visit, office visit, or discharge. All e/m 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.

Only one hospital visit (CPT Codes 99231-99233) per day for the same patient, same provider/same specialty in same group is payable. Do not submit more than one service, as this carrier will pay for the first hospital visit submitted. The second service will be denied. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, select a level of service representative of the combined visits and submit the appropriate code for that level.

If the reason for the second visit is an unrelated problem that could not have been addressed in the first encounter, the reason for the second visit must be clearly documented in the documentation field of the electronic claim or as an attachment to the CMS 1500 Claim Form.

- Example: Identify when a provider is practicing in an unrecognized subspecialty (e.g., Emergency Physician, retinal specialist, hand surgery, etc.) and list the diagnosis code that is unrelated to the other E/M service for the same date
- If denied, you may request a Redetermination including documentation so that Palmetto GBA can reconsider payment for the second visit

Physicians who provide an initial visit to a patient during hospital care shall report an initial hospital care code (CPT 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.

The principal physician of record shall append the modifier “-AI”, Principal Physician of Record, to the initial nursing facility care code (CPT 99304-99306). 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 Hospital Discharge Management Service

The hospital discharge management service (CPT 99238-99239) is the only service payable when a patient is discharged on a date other than the date of admission.

- Example: If provider bills CPT 99233 (subsequent hospital visit) and CPT 99238 (discharge) on same date, the discharge will be paid

Emergency Room Codes

Emergency room codes are only payable when the beneficiary is seen in the emergency department – place of service 21.

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