Coding Policy

Medical Visits

CODING POLICY NUMBER: 52

Effective Date: 1/1/2024

Last Review Date: 1/2024

Next Annual Review: 2025

POLICY STATEMENT.. 1

PROCEDURE 2

REFERENCES... 6

POLICY REVISION HISTORY... 7

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies"). **The full Company portfolio of current coding policies is available online and can be accessed here.**

POLICY APPLICATION

☒ Providence Health Plan Participating Providers ☒ Non-Participating Practitioners

☒ Commercial ☒ Medicaid/Oregon Health Plan ☒ Medicare

POLICY STATEMENT

I. Company allows only one Evaluation and Management (E/M) service per day from a single provider. Either a problem/illness-related E/M or a preventive E/M service may be billed, but not both. When the patient is admitted to a facility during an encounter at another site of service, only the facility admission may be billed.

   A. Exception: Hospital discharge and admission to nursing home on the same day will both be reimbursed. Documentation must support two separate services.

   B. Exception for patients under the age of 18 years: When a significant, separately identifiable problem-related E/M service is performed on the same day as a preventive E/M service for patients under the age of 18, the E/M code for an established patient (99212-99215) may be reported with the preventive service. Modifier 25 and modifier 52 must both be appended to the problem-related E/M code to allow it to be paid with the preventive services E/M code. The problem-

related E/M code (99212-99215) will be paid at 50% of the usual allowable for that service. See "Procedure" for details.

II. Company defines a new patient in an outpatient setting as one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice within the past three years.

III. Company defines an initial service in a facility setting as one that occurs when the patient has not received any professional services from the provider or a provider of the same specialty who belongs to the same group practice during the inpatient, observation, or nursing facility stay.

IV. Counseling to family members with the patient not present is covered only where the primary purpose of such counseling is treatment of the patient's condition. Counseling primarily concerned with effects of the patient's condition on the family member is not reimbursed as part of the physician's treatment of the patient.

V. Time must be documented for procedures performed on the same day as an E/M service if the level of service for the E/M code is chosen based on time rather than medical decision making. The time documented for the procedure must be entirely separate from the time documented for the E/M service. The documentation for the E/M visit must show a service that is separate from the usual pre- and post-procedure evaluation included with the procedure.

See also Coding Policy 31.0 (Modifier 25).

PROCEDURE

GENERAL

Multiple E/M Services

When cognitive services are performed involving medical E/M services, only one visit per day may be reported by the same provider or provider of the same specialty within the same group. When more than one E/M service is performed on the same date by the same provider or provider of the same specialty within the same group, the work performed at each encounter may be combined and billed as one E/M service.

Preventive E/M with Problem-Related E/M

Patients 18 years old or older: When both a problem-related E/M service and a preventive E/M service are reported on the same date by the same provider, **Company will initially reimburse the preventive**

service only. If the provider encounters signs and/or symptoms during a preventive visit that significantly alter the history, exam, and medical decision making that would have been performed as part of a routine preventive service, then the appropriate level problem-related E/M code may be billed rather than a preventive care E/M code. Management of chronic and/or stable conditions, abnormal findings on review of systems and/or diagnosis and treatment of minor clinical conditions are considered part of a normal preventive service. The addition of modifier 25 will not affect this edit. Providers may appeal these denials with chart notes. Denials will be overturned only if the documentation shows a significant, separately identifiable E/M service was performed with the preventive E/M service. (See also Coding Policy 04.0.18.)

Patients under the age of 18 years: Occasionally, a significant new or different abnormality/medical problem is encountered during the preventive visit, or there may be a change or exacerbation of a previous condition revealed during the examination that requires a significant amount of time to address. When this occurs, and elements of a problem-related E/M service are provided that are entirely separate from the comprehensive history and exam performed as part of the preventive service, Company will reimburse both the preventive medicine service code and 50% of the allowed amount for problem-related E/M service code.

- Only codes for established patient problem-related E/M services may be billed with preventive services, even if the preventive code is for a new patient. The problem-related E/M code must be appended with both modifier 25 and modifier 52. If the problem-related code is not submitted with both modifier 25 and modifier 52 appended, it will not be reimbursed.
- Separate documentation is not required, but it must be clear to an auditor which documentation relates to the preventive E/M and which relates to the illness E/M. The chief complaint for the illness E/M should be clearly identified in the record. The illness complaint or abnormal findings should not be intermixed within the body of the physical exam documentation.
- If addressed at the visit, treatment of a chronic condition must show a change or exacerbation of the condition to justify billing a separate visit. It is not appropriate to bill a separate visit for a condition that is managed by a different provider.
- Documentation should show how much time was spent performing the problem-related E/M visit.
- Examples of services that do not support a separate E/M visit include (but are not limited to):

    - Prescription refills and/or samples for chronic stable conditions
    - Rule out X-rays
    - Rule out blood work
    - Referral to another physician or qualified healthcare professional
    - Decision to “observe” (is not considered treatment)
    - Chronic or past diagnosis(es) that are not treated
    - Results of test(s)
    - Minor clinical conditions (such as cold, ear infection, rash, etc.) identified during the preventive examination

Prolonged Services

PHP allows prolonged services reported with the following HCPCS codes established by Centers for Medicare and Medicaid Services (CMS):

- G2212: Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services). (Do not report G2212 on the same date of service as 99358, 99359, 99415, 99416.) (Do not report G2212 for any time unit less than 15 minutes.)

- G0316: Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 for any time unit less than 15 minutes.)

- G0317: Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services). (Do not report G0317 for any time unit less than 15 minutes.)

- G0318: Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report G0318 for any time unit less than 15 minutes.)

Company follows all CMS guidelines for use of prolonged services codes G2212, G0316, G0317, and G0318, including, but not limited to, the following:

- Initial inpatient and observation care do not include work performed on prior days by the same practitioner, therefore prolonged visit codes may be used only for time spent on the day of the encounter.

The table below, copied from CMS Final Rule for CY 2023 (Table 24), gives threshold times for reporting prolonged visits:

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	125 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a
Emergency Department Visits	n/a	n/a	n/a
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit +3 days after
NF Discharge Day Management	n/a	n/a	n/a
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	n/a	n/a	n/a

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe, and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.

PHP does not accept the following CPT codes to report prolonged services:

- 99417
- 99418
- 99358
- 99359

Critical Care Services

- CPT code 99291 may be reported for the first 30-74 minutes of critical care services furnished to a patient on a given date. Critical care services of fewer than 30 minutes total on a given date are not reported with CPT code 99291 but may be reported with the appropriate E/M code based on the site of service. CPT code 99291 may be reported only once per day by providers of the same specialty within the same provider group.
- CPT code 99292 may be reported for additional, complete 30-minute time increments furnished to the same patient (74 + 30 = 104 minutes). This policy is the same for critical care whether the patient is receiving care from one physician, multiple practitioners in the same group and specialty who are providing concurrent care, or physicians and NPPs who are billing critical care as a split (or shared) visit. CPT code 99292 may not be billed for increments of time less than 30 minutes.
- When two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service, one physician may report CPT code 99291 for the first 30-74 minutes of critical care, and the other physician(s) may report critical care services with CPT code 99292 for each additional 30 minutes. Although CPT code 99292 is an add-on code that is supposed to be billed in conjunction with CPT code 99291, Company allows CPT code 99292 to be billed without CPT code 99291 in this scenario. ** Note: Total time

must meet or exceed 104 minutes for both CPT code 99291 and CPT code 99292 to be billed for the same patient by practitioners of the same specialty in the same group practice. CPT code 99292 may never be reported for increments of time less than 30 minutes.

Health Behavior Assessment with Other E/M Services

When a health behavior assessment and a preventive service are billed on the same date of service, only the preventive service will be allowed. When a health behavior assessment and an illness-related E/M service are billed on the same date of service, only the health behavior assessment service will be allowed. The addition of modifier 25 will not affect the edit for either of these code pairs.

Ophthalmology Visit with Other E/M Services

When an Ophthalmology service is billed together with a preventive care or illness-related E/M service, only the Ophthalmology visit will be allowed. The addition of modifier 25 will not affect this edit.

Shared Medical Visits

A shared medical visit is when multiple patients are seen as a group for follow-up or routine care. These visits are voluntary for patients and must be used for delivery of care, NOT for classes.

CPT codes 99212 and 99213 are the only codes Company allows for shared medical visits. The CPT requirements for reporting either CPT code 99212 or CPT code 99213 must be supported by care given to that individual patient and documented in the patient's medical record.

CPT code 99212 or 99213 may be paid for shared medical visits when all the following criteria are met:

- A physician is in attendance during the visit.
- The patient is an established patient already enrolled in the practice.
- The group visit is disease- or condition-specific; however, this does not preclude coverage of group visits that are designed to address aspects of multiple chronic conditions for patients with co-morbid conditions.
- Patient attendance is completely voluntary; patients are entitled to have individual appointments as needed.
- Adequate facilities and time are provided for group visits.
- Appropriate staff members are maintained to facilitate the group discussion and coordinate the meeting.
- Individual as well as group interactions are documented in the patient's medical record.

REFERENCES

1. CMS/Medicare Rules and Regulations
2. Current Procedural Terminology (CPT)

3. Providence Health Plan Coding Edits

POLICY REVISION HISTORY

Date	Revision Summary
3/2023	Annual review (converted to new template 5/2023). Original policy effective date: 3/2003
5/2023	Added statement showing time spent performing procedure must be documented and separate from time used to choose level of E/M service billed
1/2024	Annual review. Removed requirement for documenting total time when both a preventive E/M and problem-related E/M performed for members under 18 years of age. Added reference to Coding Policy 04.0.18 to show denial of problem-related E/M billed with preventive E/M for members 18 years and older may be appealed when appropriate.
2/2024	Updated description for HCPCS code G2212.