Coding Policy **Policy and Procedure**		
SUBJECT: Coding Policy 52.0 Medical Visits	DEPARTMENT: **Health Care Services**	
ORIGINAL EFFECTIVE DATE: 03/2003	DATE(S) REVIEWED/REVISED: 03/04-01/07, 01/08, 01/09, 01/10, 01/11, 06/11, 01/12, 01/13, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 01/21, 07/21, 01/22, 08/22	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 52.0**	PAGE: **1 of 3**

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").

APPLIES TO:
Health Plan Providers
All Lines of Business

POLICY:
Company allows only one Evaluation and Management (E/M) service per day from a single provider. Either an illness-related E/M or a preventive E/M service may be billed, but not both.

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

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.

See also Coding Policy 31.0 (Modifier 25).

PROCEDURE:
<u>Multiple E/M Services</u>:
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.

<u>Preventive E/M With Illness-Related E/M</u>:
When both an illness-related E/M service and a preventive care E/M service are reported on the same date by the same provider, **Company will 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 illness-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.

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.

Multiple Providers Billing Critical Care:
Critical care is reported with a base code (CPT code 99291) for the first 30-74 minutes of critical care and an add-on code (CPT code 99292) for each additional 30 minutes. 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.

Generally, add-on codes must be billed with a parent code, but Company makes an exception in the case of CPT code 99292 when multiple physicians of the same specialty in the same group practice provide critical care for the same patient. 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, and the other physician(s) may report critical care services with CPT code 99292. In this scenario, Company will allow payment for CPT code 99292 even though it is billed without CPT code 99291.

REFERENCE:

CMS/Medicare Rules and Regulations
Current Procedural Terminology (CPT)
Providence Health Plan Coding Edits