SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.15 EVALUATION & MANAGEMENT SERVICES

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

EVALUATION AND MANAGEMENT SERVICES

Level of Office Visit

- When billing evaluation & management (E&M) CPT codes 99202-99205 and 99211-99215, your medical record documentation must prove medical necessity of a service in addition to the required components of the code. It is not appropriate to bill a higher-level E&M service when a lower level is warranted.
- The correct code for an E&M visit should be chosen based on the complexity of the visit. This is determined by the complexity of medical decision making as documented in the record or the total time dedicated to the patient on the given date of service.
- Either medical decision making or total time can be used to determine the correct code, but these two elements cannot be combined.
- Complexity of medical decision making is based on a) Number and Complexity of Problems Addressed at the Encounter; b) Amount and/or Complexity of Data to be Reviewed and Analyzed; and c) Risk of Complications and/or Morbidity or Mortality of Patient Management.
- Time for codes 99202-99205 and 99211-99215 is defined as the total time spent by the provider on the day of the encounter. Time does not include time in activities normally performed by clinical staff. Time must be documented separately to indicate the pre-service, intraservice and post-service times.
- Upon audit, providers found to have a lack of medical decision making documented in the medical record, for the billed E&M services, will be contacted and risk recoupment of all overpaid amounts.
- Providers must follow 2021 documentation guidelines for coding all E&M services. For your convenience, these guidelines can be found both in the *CPT 2021 Professional Edition* published by the American Medical Association and at the Centers for Medicare and Medicaid Services (CMS) website www.cms.gov.

Split/Shared E&M Services

A split/shared E&M service is an encounter with a patient where a physician and a non-physician practitioner (e.g., NP, PA, CNM) each personally perform a portion of an E&M visit face-to-face with the same patient on the same date of service. Please note that providers must meet the following requirements in order to bill a split/shared E&M visit under the physician's provider number:

- The physician must provide a face-to-face visit with the patient.
- The physician must document in a separate note the E&M work that they personally performed. It is not sufficient for the physician to countersign the medical record or document "seen and agree." The physician must document the work that they personally performed during the visit.

- If time is used to select the E&M code for a split/shared visit, the time spent by the physician and other qualified health care provider is summed to determine the total visit time. Also, as outlined in the *CPT 2021 Professional Edition*, "Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient care, only the time of one individual should be counted)."
- The physician must justify their involvement in the patient care by legibly signing the medical record.

In addition, the following requirements apply to split/shared E&M services:

- Services must be rendered by the attending physician and specified non-physician practitioners: nurse practitioners, physician assistants and certified nurse-midwives.
- The attending physician and the non-physician practitioner must be part of the same group practice, either through direct employment or a contractual arrangement, which links the two individuals.

Only one provider should bill for the E&M service.

Consultation Codes

Effective for dates of service on and after March 1, 2021, Consultation CPT codes 99241-99245 and 99251-99255 will be considered invalid for submission to Blue Cross. We will follow the CMS guidelines whereby the E&M procedure codes that describe the office visit, hospital care, nursing facility care, home service or domiciliary/rest home care service should be billed instead of consultation codes 99241-99245 or 99251-99255.

Reduction for E&M Office Visit on Same Day as Preventative Visit

Effective for dates of service on and after March 1, 2021, E&M office visit reimbursement will be reduced by 50% when an E&M office visit for a member is performed by the same provider on the same day as a preventive medical exam and the service is billed to indicate a significant separately identifiable E&M service was performed.