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 Blue Cross and Blue Shield of Louisiana makes 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.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.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 our policies. Louisiana Blue 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 are proprietary and confidential and may constitute trade secrets.

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 current CPT documentation guidelines for coding all E&M services. For your convenience, these guidelines can be found both in the *CPT Professional Edition* published annually 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. 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 healthcare 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

Consultation CPT codes 99242-99245 and 99252-99255 are considered invalid for submission to Louisiana Blue. We 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 99242-99245 or 99252-99255.

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.

Advance Care Planning

Counseling patients and their caregivers on advance care planning for end-of-life is an important part of their care. Louisiana Blue will reimburse qualified health professionals (MD/DO, MSW, PA, NP, etc.) who submit claims for advance care planning for end-of-life counseling services with their patients if all of the following conditions are met:

- The visit should consist of an informative discussion between qualified health professionals, patient, and/or the patient's family regarding end-of-life treatment options.
- The discussion must be clearly documented in the medical record.

- Unless they do not have the capacity to participate, the patient must participate face-to-face in some or all of the discussion.
- Services must be provided by a licensed care provider (MSW, PA, NP, etc.) or provided under the supervision of a licensed physician. Counseling may include completion of legal advance directive documents, such as a living will or healthcare power of attorney, mental health directives, portable medical orders such as LaPOST, and/or other instructions for preferred medical treatment.

Advance care planning services are represented by CPT codes 99497 and 99498. Member benefits for advance care planning services may vary by Louisiana Blue plan. Prior to rendering services, always verify members' benefits through iLinkBlue to determine applicable benefits and any maximum benefit limitations.

Advance care planning services may be provided in-person or through audiovisual telehealth. Advance care planning services are not eligible to be billed as an audio-only telehealth service. Appropriate modifiers should be used when the service is provided via a telehealth platform. Please refer to Section 5.37 Telemedicine/Telehealth of this manual for further instruction on submitting claims for telehealth services.

Advance care planning cannot be billed on the same date of service as a critical care/intensive care service (For example, CPT codes 99291-99292, 99468-99469, 99471-99472, 99475-99480). Except for these services, if a significant, separately identifiable E&M service is performed unrelated to advance care planning, the advanced care planning service may be eligible for separate reimbursement. Modifier 25 must be submitted with the E&M code for proper claims processing if a significant, separately identifiable E&M service is performed. Additionally, no element of the E&M service or time spent performing the E&M service may be used in calculating the time of the advance care planning service. Similarly, no element of or time spent performing the advance care planning service may be used in determining the level of E&M service provided.

Advance care planning reimbursement will be reduced by 50% when an advanced care planning service for a member is performed by the same provider on the same day as a significant, separately identifiable E&M service.