

Payment Policy: Professional Services (Visit Codes) Billed With Labs

Reference Number: CC.PP.019

Product Types: ALL

Effective Date: 01/01/2013

Last Review Date: 3/10/2018

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

Providers may receive reimbursement for visit codes (evaluation and management services) in addition to a laboratory test, but only when the provider performs a distinct and separately identifiable service in addition to the test. If a separate and significant evaluation and management service is provided to the patient in addition to the lab work, modifier -25 should be appended.

Application

This policy applies to Professional Claims.

Reimbursement

Claims Reimbursement Edit

The Health Plan's clinical code editing software will flag all provider claims billed with the modifier -25 for prepayment clinical validation. Clinical validation occurs *prior to claims payment*. Once a claim has been clinically validated, it is either released for payment or denied for incorrect use of the modifier.

Rationale for Edit

Providers should not bill an evaluation and management code unless a significant and separate E/M service is provided. Billing an E/M code when the only service is obtaining specimens for laboratory procedures is inappropriate.

Modifier -25 should only be used to indicate that a "significant, separately identifiable evaluation and management service (was provided) by the same physician on the same day of the procedure or other service."

Pre-payment Clinical Claims review

A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. If medical records do not indicate that significant, separately identifiable services were performed, the health plan covers the primary procedure or other service, and denies the secondary E/M billed with Modifier 25.

To avoid incorrect denials providers should assign all applicable diagnosis codes that indicate what the need for additional E/M services.

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Documentation Requirements

The following guidelines will be used to determine whether or not modifier 25 was used appropriately. If any one of the following conditions is met then reimbursement for the E/M service is recommended

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient’s condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- If a provider bills supplies or equipment, on our around the same date, that are unrelated to the procedure performed but would have required an E/M services to determine the patient’s need

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99201-99205	Office or other outpatient visit for the evaluation and management of a new patient
99211-99215	Office or other outpatient visit for the evaluation and management of an established patient
99281-99285	Emergency Department Services
99291-99292	Critical Care Services
99241-99245	Office or other outpatient consultations

Modifier	Descriptor
-25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

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Related Documents or Resources

1. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.
2. 2. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications.
3. 3. American Medical Association, Current Procedural Terminology (CPT®) and associated.

References

1. *Current Procedural Terminology (CPT®)*, 2017

Revision History	
03/07/2017	Converted to new template and conducted annual review.
03/10/2018	Reviewed and revised policy.

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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