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

Reference Number: LA.PP.019
Product Types: ALL
Effective Date: 08/2020 Coding Implications
Last Review Date: 08/2022~~0~~ 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 significant and separately identifiable 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
Louisiana Healthcare Connections code editing software will flag all provider claims billed with 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 separately identifiable 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 the need for additional E/M services.

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.

- 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
- A provider bills supplies or equipment, on or 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 2019, 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
99288	Other Emergency 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

Related Documents or Resources

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

References

1. *Current Procedural Terminology (CPT®)*, 2019

Revision History	
08/15/2020	Converted corporate to local policy.
08/26/2022	Annual Review; Removed clinical and added payment policy in "Important Reminder" section

Important Reminder

This ~~clinical policy~~payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this ~~clinical policy~~payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this ~~clinical policy~~payment policy. This ~~clinical policy~~payment policy is consistent with standards of medical practice current at the time that this ~~clinical policy~~payment policy was approved.

The purpose of this ~~clinical policy~~payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This ~~clinical policy~~payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this ~~clinical policy~~payment policy. This ~~clinical policy~~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 ~~clinical policy~~payment policy and any applicable legal or regulatory requirement, the requirements of

law and regulation shall govern. LHCC retains the right to change, amend or withdraw this ~~clinical policy~~payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This ~~clinical policy~~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 ~~clinical policy~~payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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

This ~~clinical policy~~payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this ~~clinical policy~~payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_