Payment Policy: Incidental Diagnostic and Laboratory Tests Billed with Evaluation and Management Services

Reference Number: LA.PP.010
Product Types: ALL
Date of Last Revision~~ew Date~~:
~~08/2022~~06~~7~~/2023

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The AMA's Current Procedural Terminology (CPT®) codes for Evaluation and Management (E/M) services represent the professional services of physicians and other qualified health care professionals. These codes include a collection of patient care services rendered on the day of the encounter and certain incidental services rendered on days without a face-to-face visit. A number of ordinarily performed physician services are included in the payment for the E/M service and are not paid separately.

The purpose of this policy is to define payment criteria for incidental diagnostic and laboratory tests when billed with E/M services.

Policy Description
Per CPT guidelines,~~The different levels of~~ E/M services "include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or location for appropriate care."[i] E/M services include seven components of physician work:

- History;
- Examination;
- Medical decision making;
- Counseling;
- Coordination of care;
- Nature of presenting problem;
- Time.

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed. Therefore the review and analysis of common diagnostic tests are included in the medical decision making component of E/M services and should be appropriately documented in the patient's medical record.

The CPT guidelines further instructs that the actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component), with

preparation of a separately distinctly identifiable signed written report, may also be reported separately, using the appropriate CPT code with modifier -26 appended. Therefore the review and analysis of those diagnostic tests and services that do not ordinarily warrant a separately identifiable signed report, but which results are documented and commented upon in the body of the physician documentation in the medical record will not be separately reimbursed.

Reimbursement
Reimbursement for the review and analysis of incidental diagnostic and laboratory tests performed during the course of an E/M service will be included in the payment for the E/M service and not reimbursed separately.

Documentation Requirements
The medical record must support the need for a separately identifiable and signed report for the diagnostic test beyond what would ordinarily be expected within the range of services that comprise an E/M service in order for separate payment to be made. Under such circumstances, a -25 modifier must be appended to the applicable E/M service to receive payment.

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 20~~19~~22, 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 and may not support medical necessity. 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
99201-99288	Outpatient, inpatient and consultation E/M services
99291-99292	Critical Care E/M Services
99304-99360	Nursing home and other domiciliary and home E/M services
99366-99429	Case management, care plan oversight, and preventative medicine E/M services
99441-99498	Other special E/M services, newborn care, care management services
99484	Case management services for behavioral health conditions
99499	Other Evaluation and Management Services

CPT Codes for physician services ordinarily bundled in to E/M services.

CPT/HCPCS Code	Descriptor

93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
94760	Noninvasive ear or pulse oximetry

References

1. *Current Procedural Terminology (CPT®)*, 20~~19~~22
2. *HCPCS Level II*, 20~~19~~22
3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 20~~19~~22
4. *ICD-10-CM Official Draft Code Set*, 20~~19~~22

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Removed clinical and added payment policy in "Important Reminder" section	08/25/2022	
Annual Review completed; removed E/M and diagnostic CPT code tables as this information can be found in the CPT manual. Changed members to members/enrollees. Added "and may not support medical necessity" to coding implications.	07~~6/20~~/2023	

Important Reminder

This 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 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 payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this 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 payment policy is effective as of the date determined by LHCC. 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. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this 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 payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members/enrollees 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/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees 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_~~