Payment Policy: Hospital Visit Codes Billed w Labs

Reference Number: LA.PP.023
~~Product Types: ALL~~
Effective Date: 08/2020 Coding Implications
Date of Last Revision: ~~07/2023~~086/2024 Revision Log

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

Policy Overview
Hospitals may receive reimbursement for visit codes (evaluation and management services) in addition to a laboratory test, but only when the hospital provides a room for an evaluation and management service by a professional. 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 outpatient hospital claims.

Reimbursement
Claims Reimbursement Edit
Louisiana Healthcare Connections code editing software ~~will flag all hospital 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.~~ contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures

Rationale for Edit
A hospital should not bill a visit code for the use of an exam room for a registered outpatient, if the patient was not seen by a provider. Billing a visit code in addition to the laboratory visit is inappropriate when the only other service performed was the collection of a specimen. Like all other procedures, room charges are included in the reimbursement for the procedure.

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

~~Pre-payment Clinical Claims review~~
~~A significant, separately identifiable E/M service is 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 primary procedure or other service will be paid and the secondary E/M billed with Modifier -25 will be denied.~~

To avoid incorrect denials, providers should assign all applicable diagnosis codes that support the E/M services reported.

Payments to providers are subject to post payment review and recovery of overpayments.

Documentation Requirements
Documentation from the physician or other qualified health care professional should indicate that an evaluation and management service was provided. The key components of an E/M service (history, examination and medical decision making) must be documented.

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 2022~~2~~4, 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.

Definitions
Not Applicable

Related Policies
Not Applicable

Related Documents or Resources
Not Applicable

References
~~1. *Current Procedural Terminology (CPT®), 2022*~~
~~2.~~1. *HCPCS Level II*, 2022~~2~~4
~~3.~~2. *International Classification of Diseases,* Tenth Revision, Clinical Modification (ICD-10-CM), 2022~~2~~4
~~4. *ICD-10-CM Official Draft Code Set*, 2022~~
~~5.~~3. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services.
~~6. *Centers for Medicare and Medicaid Services*, National Correct Coding Initiative (NCCI) publications.~~
~~7.~~4. *American Medical Association*, Current Procedural Terminology (CPT®) and associated, 2022~~2~~4

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	08/29/2022	
Annual review; code tables removed to eliminate content redundancy	07/2023	10/19/23
Annual review; Remove pre payment clinical validation verbiage per LDH and added could be subject to post pay review and recoupments; updated reference dates	086/2024	

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.~~