



Related MLN Matters Article #: MM4032

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Payment for Office/Outpatient E/M Visits (Codes 99201-99215)

Key Words

MM4032, CR4032, Office, Visits, Codes, E/M, 99201, 99215, Evaluation, Management, CR3621, MM3621, 12, 30.6.7

Provider Types Affected

Physicians billing Medicare carriers for drug administration and for evaluation and management (E/M) services

Key Points

- The effective date of the instruction is January 1, 2004, for chemotherapy and non-chemotherapy drug infusion codes and January 1, 2005 for therapeutic and diagnostic injection codes.
- The implementation date is January 3, 2006.
- MM4032 clarifies and corrects the definition of “new patient” and “physician in a group practice” for billing evaluation and management (E/M) services and updates the policy on billing E/M services with drug administration codes in the Medicare Claims Processing Manual.
- Chapter 12, Section 30.6.7 is updated stating that Medicare will pay for medically necessary office/outpatient visits billed on the same day as a drug administration service with modifier -25 when the modifier indicates that a separately identifiable E/M service was performed that meets a higher complexity level of care than a service represented by CPT code 99211.
- Chapter 12, Section 30.6.7 defines “new patient” for the E/M visit code and reads as follows: Interpret the phrase “new patient” to mean a patient who has not received any professional services, i.e., evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.
- For example, if a professional component of a previous procedure is billed in a three-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic

test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

- Paragraph B of Chapter 12, Section 30.6.7, clarifies “physician in a group practice” for office/outpatient E/M Visits provided on the same day for unrelated problems as follows: As for all other E/M services except where specifically noted, carriers may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office or outpatient setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).
- Paragraph D of the Chapter 12, Section 30.6.7 describes drug administration services and E/M visits billed on the same day of service as follows: Carriers must advise physicians that CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or non-chemotherapy drug infusion service (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 14, 2004, to also include a therapeutic or diagnostic injection code (effective January 1, 2005). Therefore, when a medically necessary, significant, and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required.

Important Links

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4032.pdf>

<http://www.cms.hhs.gov/transmittals/downloads/R731CP.pdf>

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