

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – Vaccinate Early to Protect Against the Flu. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And, don't forget to immunize yourself and your staff.

Get the Flu Vaccination -- Not the Flu. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/MLNProducts/35_PreventiveServices.asp on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Number: MM7405

Related Change Request (CR) #: 7405

Related CR Release Date: August 26, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R147BP and R2282CP

Implementation Date: November 28, 2011

Clarification of Evaluation and Management (E/M) Payment Policy

Provider Types Affected

Physicians, non-physician practitioners (NPP), and hospices billing Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, and A/B Medicare Administrative Contractors (A/B MAC) for certain services to Medicare beneficiaries are affected by this article.

What You Need to Know

This article, based on Change Request (CR) 7405, alerts physicians, NPPs and hospices that the Centers for Medicare & Medicaid Services (CMS) recognized the newly created Current Procedural Terminology (CPT) subsequent observation care

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codes (99224-99226). The article also clarifies the use of Evaluation and Management (E/M) Codes by providers for services in various settings.

Medicare contractors will not search their files to adjust claims already processed, but will adjust claims brought to their attention. Be sure your billing staffs are aware of these changes.

Background

In the Calendar Year (CY) 2010 Physician Fee Schedule (PFS) final rule with comment period (CMS-1413-FC), CMS eliminated the payment of all CPT consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation Healthcare Common Procedure Coding System (HCPCS) G-codes.

In the CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created CPT subsequent observation care codes (99224-99226).

All references to billing CPT consultation codes in the "Medicare Benefit Policy Manual", Chapter 15, and the "Medicare Claims Processing Manual", 12, are revised, as a result of CR7405, to reflect the current policy on reporting E/M services that would otherwise be described by CPT consultation codes.

References to billing observation care codes in the "Medicare Claims Processing Manual", Chapter 12, section 30.6, are also revised to account for the new subsequent observation care codes (99224-99226).

Key Points of CR 7405

Consultation Codes No Longer Recognized

Effective January 1, 2010, CPT consultation codes were no longer recognized for Medicare Part B payment. A previous article, MM6740, Revisions to Consultation Services Payment Policy, issued on December 14, 2009, informed you that you must code patient evaluation and management visits with E/M codes that represent where the visit occurred and that identify the complexity of the visit performed. (MM6740, Revisions to Consultation Services Payment Policy, is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM6740.pdf> on the CMS website.)

- CMS instructed physicians (and qualified NPPs where permitted) billing under the Physician Fee Service (PFS) to use other applicable E/M codes to report the services that could be described by CPT consultation codes.
- CMS also provided that, in the inpatient hospital setting, physicians (and qualified NPPs where permitted) who perform an initial E/M service may bill the initial hospital care codes (99221 – 99223).

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Reporting Initial Hospital Care Codes

CMS is aware of concerns pertaining to reporting initial hospital care codes for services that previously could have been reported with CPT consultation codes, for which the minimum key component work and/or medical necessity requirements for CPT codes 99221 through 99223 are not documented.

- Physicians may bill initial hospital care service codes (99221-99223), for services that were reported with CPT consultation codes (99241 – 99255) prior to January 1, 2010, when the furnished service and documentation meet the minimum key component work and/or medical necessity requirements. Physicians must meet all the requirements of the initial hospital care codes, including “a detailed or comprehensive history” and “a detailed or comprehensive examination” to report CPT code 99221, which are greater than the requirements for consultation codes 99251 and 99252.
- In situations where the minimum key component work and/or medical necessity requirements for initial hospital care services are not met, subsequent hospital care CPT codes (99231 and 99232) could potentially be reported for an E/M service that could be described by CPT consultation code 99251 or 99252.
- Subsequent hospital care CPT codes 99231 and 99232, respectively, require “a problem focused interval history” and “an expanded problem focused interval history.” An E/M service that could be described by CPT consultation code 99251 or 99252 could potentially meet the component work and medical necessity requirements to report 99231 or 99232. Physicians may report a subsequent hospital care CPT code for services that were reported as CPT consultation codes (99241 – 99255) prior to January 1, 2010, where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.
- Reporting CPT code 99499 (Unlisted evaluation and management service) should be limited to cases where there is no other specific E/M code payable by Medicare that describes that service. Reporting CPT code 99499 requires submission of medical records and contractor manual medical review of the service prior to payment. Contractors shall expect reporting under these circumstances to be unusual.

Medicare contractors have been advised to expect changes to physician billing practices accordingly. Contractors will not find fault with providers who report subsequent hospital care codes (99231 and 99232) in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected),

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even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

Billing Visits Provided in Skilled Nursing Facilities and Nursing Facilities

The general policy of billing the most appropriate visit code, following the elimination of payments for consultation codes, will also apply to billing initial visits provided in skilled nursing facilities (SNFs) and nursing facilities (NFs) by physicians and NPPs who are not providing the federally mandated initial visit. If a physician or NPP is furnishing that practitioner's first E/M service for a Medicare beneficiary in a SNF or NF during the patient's facility stay, even if that service is provided prior to the federally mandated visit, the practitioner may bill the most appropriate E/M code that reflects the services the practitioner furnished, whether that code be an initial nursing facility care code (CPT codes 99304-99306) or a subsequent nursing facility care code (CPT codes 99307-99310), when documentation and medical necessity do not meet the requirements for billing an initial nursing facility care code.

CPT Subsequent Observation Care Codes

In CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created CPT subsequent observation care codes (99224-99226).

- For the new subsequent observation care codes, the current policy for initial observation care also applies to subsequent observation care.
- Payment for a subsequent observation care code is for all the care rendered by the treating physician on the day(s) other than the initial or discharge date.
- All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.
- In the rare circumstance when a patient receives observation services for more than 2 calendar dates, the physician will bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.

Additional Information

The official instruction, CR 7405, was issued to your FI, RHHI, carrier and A/B MAC via two transmittals. The first updates the "Medicare Benefit Policy Manual" and is at <http://www.cms.gov/Transmittals/downloads/R147BP.pdf> on the CMS website. The second transmittal updates the "Medicare Claims Processing Manual" and is at <http://www.cms.gov/Transmittals/downloads/R2282CP.pdf> on the same site. If you have any questions, please contact your FI, RHHI, carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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