

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 147	Date: AUGUST 26, 2011
	Change Request 7405

SUBJECT: Clarification of Evaluation and Management Payment Policy

I. SUMMARY OF CHANGES: In the Calendar Year (CY) 2010 Physician Fee Schedule (PFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare and Medicaid Services (CMS) eliminated the payment of all Current Procedural Terminology (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 consultation codes in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 and Pub. 100-04, Medicare Claims Processing Manual, chapter 12 are revised to reflect the current policy on consultation codes. References to billing observation care codes in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6 are revised to account for the new subsequent observation care codes (99224-99226).

EFFECTIVE DATE: January 1, 2011

IMPLEMENTATION DATE: November 28, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/30/Physician Services

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirement

Pub. 100-02	Transmittal: 147	Date: August 26, 2011	Change Request: 7405
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SUBJECT: Clarification of Evaluation and Management Payment Policy

Effective Date: January 1, 2011

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I. GENERAL INFORMATION

A. Background: In the Calendar Year (CY) 2010 Physician Fee Schedule (PFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the payment of all Current Procedural Terminology (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 Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 and Pub. 100-04, Medicare Claims Processing Manual, chapter 12 are revised to reflect the current policy on reporting evaluation and management (E/M) services that would otherwise be described by CPT consultation codes. References to billing observation care codes in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6 are revised to account for the new subsequent observation care codes (99224-99226).

B. Policy: Effective January 1, 2010, CPT consultation codes were no longer recognized for Medicare Part B payment. As explained in CR 6740, Transmittal 1875, Revisions to Consultation Services Payment Policy, issued on December 14, 2009, physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. CMS instructed providers billing under the 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 nonphysicians where permitted) who perform an initial E/M service may bill the initial hospital care codes (99221 – 99223).

CMS is aware of concerns pertaining to reporting initial hospital care codes for services that previously could have been reported with CPT consultation codes and for which the minimum key component work and/or medical necessity requirements for CPT codes 99221 through 99223 are not documented. Providers may report CPT code 99221 for an E/M service if the requirements for billing that code, which are greater than CPT consultation codes 99251 and 99252, are met by the service furnished to the patient.

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 meet requirements to be reported for an E/M service that could be described by CPT consultation code 99251 or 99252. Contractors shall expect changes to physician billing practices accordingly. Medicare contractors shall not find fault with providers who report a subsequent hospital care code (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), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

The general policy of billing the most appropriate visit code, following the elimination of payments for consultation codes, shall also apply to billing initial visits provided in skilled nursing facilities (SNFs) and

nursing facilities (NFs) by physicians and nonphysician practitioners (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.

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). 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 ordering 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 shall bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility is indicated by an “X” in each applicable column)								
		A/B/M/A/C	D/M/E/M/A/C	F/I	C/A/R/E/R	R/H/R/I	Shared-System Maintainers			
						F/S/S	M/S	V/S	C/W/F	
7405-02.1	Contractors shall be in compliance with the instructions found in Pub 100-04, Medicare Claims Processing Manual, chapter 12 and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15.	X		X	X	X				
7405-02.2	Contractors shall allow providers to bill for a subsequent hospital care code even if it is for the provider’s first evaluation and management service to the inpatient during the hospital stay.	X		X	X	X				
7405-02.3	Contractors shall allow providers to bill for an initial nursing facility care code or subsequent nursing facility care code, even if it is provided prior to the initial federally mandated visit.	X		X	X	X				
7405-02.4	As with all E/M services, contractors shall monitor subsequent observation care codes (99224-99226) to prevent payment for two or more E/M services by the same physician/nonphysician practitioner (or physician/nonphysician practitioner of the same specialty from the same group practice), unless an	X		X	X	X				

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)										
		A/B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				Other	
	appropriate modifier is appended.											
7405-02.5	Contractors shall not search their files to adjust claims already processed, but shall adjust claims brought to their attention within a timely filing period.	X		X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/ B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTH ER	
7405-02.6	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X	X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): For payment policy questions contact Erin Smith at (410) 786-0763 (e-mail: erin.smith@cms.hhs.gov)

For Part A claims processing questions, contact Wendy Tucker at (410) 786-3004 (email: wendy.tucker@cms.hhs.gov)

For Part B claims processing questions, contact Kathleen Kersell at (410) 786-2033 (e-mail: kathleen.kersell@cms.hhs.gov) or Joscelyn Lissone at (410) 786-5116 (e-mail: Joscelyn.lissone@cms.hhs.gov)

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30 - Physician Services

(Rev. 147, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. General

Physician services are the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery, consultation, and care plan oversight.

The physician must render the service for the service to be covered. (See Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §70, for definition of physician.) A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service.

Professional services of the physician are covered if provided within the United States, and may be performed in a home, office, institution, or at the scene of an accident. A patient's home, for this purpose, is anywhere the patient makes his or her residence, e.g., home for the aged, a nursing home, a relative's home.

B. Telephone Services

Services by means of a telephone call between a physician and a beneficiary, or between a physician and a member of a beneficiary's family, are covered under Medicare, but carriers may not make separate payment for these services under the program. The physician work resulting from telephone calls is considered to be an integral part of the prework and postwork of other physician services, and the fee schedule amount for the latter services already includes payment for the telephone calls. See §270 *of this manual* for coverage of telehealth services.

C. Consultations

As of January 1, 2010, CMS no longer recognizes consultation codes for Medicare payment, except for inpatient telehealth consultation HCPCS G-codes. Instead, physicians and qualified nonphysician practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code. For further detail regarding reporting services that would otherwise be described by the CPT consultation codes (99241-99245 and 99251-99255), see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6. For detailed instructions regarding reporting telehealth consultation services and other telehealth services, see Pub. 100-04, chapter 12, section 190.3.

D. Patient-Initiated Second Opinions

Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.

E. Concurrent Care

Concurrent care exists where more than one physician renders services more extensive than consultative services during a period of time. The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.

In order to determine whether concurrent physicians' services are reasonable and necessary, the carrier must decide the following:

1. Whether the patient's condition warrants the services of more than one physician on an attending (rather than consultative) basis, and
2. Whether the individual services provided by each physician are reasonable and necessary.

In resolving the first question, the carrier should consider the specialties of the physicians as well as the patient's diagnosis, as concurrent care is usually (although not always) initiated because of the existence of more than one medical condition requiring diverse specialized medical or surgical services. The specialties of the physicians are an indication of the necessity for concurrent services, but the patient's condition and the inherent reasonableness and necessity of the services, as determined by the carrier's medical staff in accordance with locality norms, must also be considered. For example, although cardiology is a sub-specialty of internal medicine, the treatment of both diabetes and of a serious heart condition might require the concurrent services of two physicians, each practicing in internal medicine but specializing in different sub-specialties.

While it would not be highly unusual for concurrent care performed by physicians in different specialties (e.g., a surgeon and an internist) or by physicians in different subspecialties of the same specialty (e.g., an allergist and a cardiologist) to be found medically necessary, the need for such care by physicians in the same specialty or

subspecialty (e.g., two internists or two cardiologists) would occur infrequently since in most cases both physicians would possess the skills and knowledge necessary to treat the patient. However, circumstances could arise which would necessitate such care. For example, a patient may require the services of two physicians in the same specialty or sub-specialty when one physician has further limited his or her practice to some unusual aspect of that specialty, e.g., tropical medicine. Similarly, concurrent services provided by a family physician and an internist may or may not be found to be reasonable and necessary, depending on the circumstances of the specific case. If it is determined that the services of one of the physicians are not warranted by the patient's condition, payment may be made only for the other physician's (or physicians') services.

Once it is determined that the patient requires the active services of more than one physician, the individual services must be examined for medical necessity, just as where a single physician provides the care. For example, even if it is determined that the patient requires the concurrent services of both a cardiologist and a surgeon, payment may not be made for any services rendered by either physician which, for that condition, exceed normal frequency or duration unless there are special circumstances requiring the additional care.

The carrier must also assure that the services of one physician do not duplicate those provided by another, e.g., where the family physician visits during the post-operative period primarily as a courtesy to the patient.

Hospital admission services performed by two physicians for the same beneficiary on the same day could represent reasonable and necessary services, provided, as stated above, that the patient's condition necessitates treatment by both physicians. The level of difficulty of the service provided may vary between the physicians, depending on the severity of the complaint each one is treating and that physician's prior contact with the patient. For example, the admission services performed by a physician who has been treating a patient over a period of time for a chronic condition would not be as involved as the services performed by a physician who has had no prior contact with the patient and who has been called in to diagnose and treat a major acute condition.

Carriers should have sufficient means for identifying concurrent care situations. A correct coverage determination can be made on a concurrent care case only where the claim is sufficiently documented for the carrier to determine the role each physician played in the patient's care (i.e., the condition or conditions for which the physician treated the patient). If, in any case, the role of each physician involved is not clear, the carrier should request clarification.

F. Completion of Claims Forms

Separate charges for the services of a physician in completing a Form CMS-1500, a statement in lieu of a Form CMS-1500, or an itemized bill are not covered. Payment for completion of the Form CMS-1500 claim form is considered included in the fee schedule amount.

G. Care Plan Oversight Services

Care plan oversight is supervision of patients under care of home health agencies or hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication with other health professionals not employed in the same practice who are involved in the patient's care, integration of new information into the care plan, and/or adjustment of medical therapy.

Such services are covered for home health and hospice patients, but are not covered for patients of skilled nursing facilities (SNFs), nursing home facilities, or hospitals.

These services are covered only if all the following requirements are met:

1. The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient's plan of care;
2. The care plan oversight (CPO) services should be furnished during the period in which the beneficiary was receiving Medicare covered HHA or hospice services;
3. The physician who bills CPO must be the same physician who signed the home health or hospice plan of care;
4. The physician furnished at least 30 minutes of care plan oversight within the calendar month for which payment is claimed. Time spent by a physician's nurse or the time spent consulting with one's nurse is not countable toward the 30-minute threshold. Low-intensity services included as part of other evaluation and management services are not included as part of the 30 minutes required for coverage;
5. The work included in hospital discharge day management (codes 99238-99239) and discharge from observation (code 99217) is not countable toward the 30 minutes per month required for work on the same day as discharge but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital;
6. The physician provided a covered physician service that required a face-to-face encounter with the beneficiary within the 6 months immediately preceding the first care plan oversight service. Only evaluation and management services are acceptable prerequisite face-to-face encounters for CPO. EKG, lab, and surgical services are not sufficient face-to-face services for CPO;
7. The care plan oversight billed by the physician was not routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician;

8. If the beneficiary is receiving home health agency services, the physician did not have a significant financial or contractual interest in the home health agency. A physician who is an employee of a hospice, including a volunteer medical director, should not bill CPO services. Payment for the services of a physician employed by the hospice is included in the payment to the hospice;
9. The physician who bills the care plan oversight services is the physician who furnished them;
10. Services provided incident to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement;
11. The physician is not billing for the Medicare end stage renal disease (ESRD) capitation payment for the same beneficiary during the same month; and
12. The physician billing for CPO must document in the patient's record the services furnished and the date and length of time associated with those services.