

EVALUATION AND MANAGEMENT SERVICES (E/M)

DOCUMENTATION AND BILLING

The history, examination and decision making are the key components in determining the level of E/M service to bill. Providers must use one of the following guidelines to determine the appropriate level of service.

The *1995 Documentation Guidelines for Evaluation & Management Services* available at www.cms.hhs.gov/MLNProducts/Downloads/1995dq.pdf

or

The *1997 Documentation Guidelines for Evaluation and Management Services* available at www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf

Chart notes must contain documentation that justifies the level of service billed.

NEW AND ESTABLISHED PATIENT

L&I uses the CPT® definitions of new and established patients. If a patient presents with a work related condition and meets the definition in a provider's practice as

- A new patient, then a new patient E/M should be billed.
- An established patient, then an established patient E/M service should be billed, even if the provider is treating a new work related condition for the first time.

MEDICAL CARE IN THE HOME OR NURSING HOME

L&I allows attending providers to charge for E/M services in:

- Nursing facilities,
- Domiciliary, boarding home or custodial care settings and
- The home

The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M is allowed with a maximum of 3 hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following CMS payment criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
99354	99201-99205, 99212-99215, 99241-99245 or 99324-99350
99355	99354 and 1 of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99304-99310
99357	99356 and 1 of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the patient (whether the service was continuous or not). Prolonged physician services without direct contact are bundled and are not payable in addition to other E/M codes. Refer to the above CMS websites for more information.

A narrative report is required when billing for prolonged evaluation and management services. See Appendix G for additional information.

USING THE –25 MODIFIER

Modifier –25 must be appended to an E/M code when reported with another procedure on the same date of service. The E/M visit and the procedure must be documented separately.

Modifier –25 must be reported in the following circumstances to be paid:

- Same patient, same day encounter at a separate visit; and
- Same physician or provider; and
- Patient condition required a “significant separately identifiable E/M service above and beyond the usual pre and post care” related with the procedure or service.

Example 1:

A worker goes to an osteopathic physician’s office to be treated for back pain. The physician:

- Reviews the history,
- Conducts a review of body systems and
- Performs a clinical examination

The physician then advises the worker that osteopathic manipulation is a therapeutic option for treatment for the condition. The physician performs the manipulation during the office visit. This is a significant separately identifiable procedure performed at the time of the E/M service.

For this office visit, the physician may bill the appropriate:

- CPT® code for the manipulation and
- E/M code with the –25 modifier

Example 2:

A worker goes to a physician’s office for a scheduled follow up visit for a work related injury. During the examination, the physician determines that the worker’s condition requires a course of treatment that includes a trigger point injection at this time. The trigger point injection was not scheduled previously as part of the E/M visit.

The physician gives the injection during the visit. This is a significant separately identifiable procedure performed at the time of the E/M service. For the same time and date of service, the physician may bill the appropriate:

- CPT® code for the injection and
- E/M code with the –25 modifier

Example 3:

A worker arrives at a physician’s office in the morning for a scheduled follow up visit for a work related injury. That afternoon, the worker’s condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen.


The provider sees the patient for a second office visit. Since the 2 visits were completely separate, both E/M services may be billed.

- The scheduled visit would be billed with the E/M code alone and
- The unscheduled visit would be billed with the E/M code with the –25 modifier.

TREATING 2 SEPARATE CONDITIONS/SPLIT BILLING POLICY

If the worker is treated for 2 separate conditions at the same visit, the charge for the service must be divided equally between the payers. If evaluation and treatment of the 2 injuries increases the complexity of the visit, a higher level E/M code might be billed. If this is the case, CPT® guidelines must be followed and the documentation must support the level of service billed. A physician would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day (see the Example 3 above). **Scheduling back-to-back appointments does not meet the criteria for using the –25 modifier.**

Separate chart notes and reports must be submitted when there are 2 different claims. The claims may be from injuries while working for 2 different employers and the employers only have the right to information about injuries they are responsible for.

**Billing Tip**

List all workers' compensation claims treated in Box 11 of the CMS-1500 form when submitting paper bills to L&I and in the remarks section when submitting electronic claims. L&I will divide charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for the accepted condition, providers must apportion their usual and customary charges equally between L&I or the self-insurer and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer does not have the right to see information about an unrelated condition.

Example 1:

A worker goes to a physician to be treated for a work related shoulder injury and a separate work related knee injury. The physician treats both work related injuries. The provider bills L&I for 1 visit listing both workers' compensation claims in Box 11 of the CMS-1500 form. L&I will divide charges equally to the claims.

Example 2:

A worker goes to a physician's office to be treated for work related injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The physician treats the work related injury and the neck pain associated with the motor vehicle accident. The provider would bill 50% of his usual and customary fee to L&I or self-insurer and 50% to the insurance company paying for the motor vehicle accident. L&I or self-insurer would only be responsible for the portion related to the accepted work related injury.

PHYSICIAN STANDBY SERVICES

The insurer pays for physician standby services when all the following criteria are met:

- Another physician requested the standby service; and
- The standby service involves prolonged physician attendance without direct face-to-face patient contact; and
- The standby physician is not concurrently providing care or service to other patients during this period; and
- The standby service does not result in the standby physician's performance of a procedure subject to a "surgical package" and
- Standby services of 30 minutes or more are provided.

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30 minute period downward. A narrative report is required when billing for physician standby services.

CASE MANAGEMENT SERVICES

Team Conferences

Team conferences may be payable when the attending provider, consultant or psychologist meets with one or more of the following:

- An interdisciplinary team of health professionals
- L&I staff
- Vocational rehabilitation counselors
- Nurse case managers
- L&I medical consultants
- Self-insured employers or their representatives
- Physical and occupational therapists and speech-language pathologists

Billing codes

Patient status	CPT® code (Physicians)	CPT® code (Nonphysicians)
Patient present	Appropriate level E&M	99366
Patient not present	99367	99368

Multiple units of 99366, 99367 and 99368 may be billed for conferences exceeding 30 minutes:

Duration of conference	Units billed
Up to 30 minutes	1 unit
Up to 60 minutes	2 units

Physical and Occupational Therapists

Physical and occupational therapists and speech-language pathologists may be paid for attendance at a team conference only when the conference is authorized in advance by the Medical Director/Associate Medical Director at L&I or the self-insured employer.

To be authorized all of the following criteria must be met:

- There is a moderate to high probability of severe, prolonged functional impairment. This may be addressed with the development of a multidisciplinary approach to the plan of care; and
- The need for a conference exceeds the expected routine correspondence/communication among healthcare/vocational providers; and
- The worker is not participating in a program in which payment for conference is already included in the program payment (For example, head injury program, pain clinic, work hardening); and
- 3 or more disciplines/specialties need to participate, including PT, OT or Speech.

To be paid for the conference the therapists must:

- Bill using CPT® code 99366 if the patient is present or 99368 if the patient is not present.
- Bill on a CMS-1500 form
- Submit a separate report of the conference; joint reports are not allowed. The conference report must include:
 - Evaluation of the effectiveness of the previous therapy plan; and
 - New goal-oriented, time-limited treatment plan or
 - Objective measures of function that address the return to work process.
 - Duration of the conference

NOTE: Providers in a hospital setting may only be paid if the services are billed on a CMS-1500 with an individual provider account number.

Telephone Calls

Telephone calls are payable to the attending provider, consultant, psychologist or other provider only when they personally participate in the call. These services are payable when discussing or coordinating care or treatment with:

- The worker
- L&I staff
- Vocational rehabilitation counselors
- Nurse case managers
- Health services coordinators (COHE)
- L&I medical consultants
- Other physicians
- Other providers
- Self-insured employers or their representatives

NOTE: L&I does not adhere to the CPT® limits for telephone calls

Telephone calls **are payable** regardless of when the previous or next office visit occurs.

ARNPs, PAs, psychologists, PTs and OTs must bill using nonphysician codes.

Telephone calls for authorization, resolution of billing issues or ordering prescriptions **are not payable**.

Duration	CPT® code (Physicians)	CPT® code (Nonphysicians)
5-10 minutes	99441	98966
11-20 minutes	99442	98967
21-30 minutes	99443	98968

Documentation Requirements

Documentation for case management services (team conferences and telephone calls) must include:

- The date, and
- The participants and their titles, and
- The length of the call or visit, and
- The nature of the call or visit, and
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists may only bill for these services when also providing consultation or evaluation.

Team conference documentation must also include a goal-oriented, time-limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, or
- Objective measures of function

The treatment plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function.

Online Communications and Consultations

Electronic online communications (e-mail) with the worker are payable only when personally made by the attending provider, consultant, psychologist or physical or occupational therapist who has an existing relationship with the worker.

Online communications must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association
- The Federation of State Medical Boards
- The eRisk Working Group for Healthcare

Services payable for communications with workers include:

- Follow up care resulting from a face-to-face visit that does not require a return to the office.
- Non-urgent consultations regarding an accepted condition when the equivalent service provided in person would have resulted in a charge.
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications.
- Discussions of return-to-work activities with workers and employers.

Services not payable include:

- Routine requests for appointments.
- Test results that are informational only.
- Requests for prescription refills.
- Consultations that result in an office visit.

Electronic communications are also payable when discussing or coordinating care, treatment or return-to-work activities with:

- L&I staff
- Vocational rehabilitation counselors
- Case managers
- L&I medical consultants
- Self-insured representatives
- Employers

NOTE: Currently, L&I staff can only respond to CAC messages by telephone or letter.

Documentation Requirements

Documentation for electronic communications must include:

- The date, and
- The participants and their titles, and
- The nature of the communication, and
- All medical, vocational or return to work decisions made.

Provider and CPT® code	Nonfacility fee	Facility fee
Physician - 99444	\$44.30	\$42.46
Nonphysician - 98969	\$44.30	\$42.46

PHYSICIAN CARE PLAN OVERSIGHT

The insurer allows separate payment for physician care plan oversight services (CPT® codes 99375, 99378 and 99380). Payment is limited to 1 per attending provider, per patient, per 30 day period. Care plan services (CPT® codes 99374, 99377 and 99379) of less than 30 minutes within a 30 day period are considered part of E/M services and **are not** separately payable.

Payment for care plan oversight to a physician providing post surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery and
- Modifier –24 is used.

The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

TELECONSULTATIONS AND OTHER TELEHEALTH SERVICES

L&I adopted a modified version of CMS's policy on teleconsultations and other telehealth services. Telehealth services and teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient and consultant.

Coverage of Teleconsultations

Teleconsultations **are covered** in the same manner as face-to-face consultations (refer to WACs 296-20-045 and –051), but in addition, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in WAC 296-20-01002 or a PhD Clinical Psychologist. A consulting DC must be an approved consultant with L&I; and
- The **referring provider** must be 1 of the following: MD, DO, ND, DPM, OD, DMD, DDS, DC, ARNP, PA or PhD Clinical Psychologist; and
- The patient must be present at the time of the consultation; and
- The exam of the patient must be under the control of the consultant; and
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the consultant; and
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer; and
- A referring provider who is not the attending must consult with the attending provider before making the referral.

Coverage of other Telehealth Services

Other procedures and office visits that are covered include:

- Follow up visits after the initial consultation
- Psychiatric intake and evaluation
- Individual psychotherapy
- Pharmacologic management
- End stage renal disease (ESRD) services

Payment of Teleconsultations and other Telehealth Services

Providers

Teleconsultations and telehealth services are paid in the same manner as face-to-face visits. The insurers will pay according to the following criteria:

- Providers must append a **GT** modifier to 1 of the appropriate services listed in the table below.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the insurer.

Providers may bill these services:
Consultation codes
Office or other outpatient visits
Psychiatric intake and assessment
Individual psychotherapy
Pharmacologic management
End stage renal disease (ESRD) services

Originating Facility

The insurer will pay an originating site facility fee for the use of the telecommunications equipment. Bill for these services with HCPCS code:

Q3014 \$34.19

The insurer will only pay for a professional service by the referring provider if it is a separately identifiable service provided on the same day as the telehealth service.

Documentation for both must be clearly and separately identified in the medical record.

Telemedicine Services Not Covered

Procedures and services **not covered** include:

- “Store and Forward” technology, asynchronous transmission of medical information to be reviewed by the consultant at a later time.
- Facsimile transmissions.
- Installation or maintenance of telecommunication equipment or systems.
- Home health monitoring.
- Telehealth transmission, per minute (HCPCS code T1014).

END STAGE RENAL DISEASE (ESRD)

L&I follows CMS's policy regarding the use of E/M services along with dialysis services. E/M services (CPT® codes 99231-99233 and 99307-99310) **are not payable** on the same date as hospital inpatient dialysis (CPT® codes 90935, 90937, 90945 and 90947). These E/M services are bundled in the dialysis service.

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital visit (CPT® codes 99221-99223),
- An initial inpatient consultation (CPT® codes 99251-99255) and
- A hospital discharge service (CPT® code 99238 or 99239)