# CMS Manual System

## Pub 100-04 Medicare Claims Processing

**Transmittal 731**

**Department of Health & Human Services (DHHS)**

**Center for Medicare & Medicaid Services (CMS)**

**Date: OCTOBER 28, 2005**

**Change Request 4032**

**SUBJECT: Payment for Office or Other Outpatient Evaluation and Management (E/M ) Visits (Codes 99201 - 99215)**

**I. SUMMARY OF CHANGES:** This transmittal clarifies and corrects the definition of "new patient" and "physician" for billing evaluation and management (E/M) services currently stated in Medicare Claims Processing, Pub. 100-04, Chapter 12, §30.6.7, and updates the policy on billing E/M services with drug administration codes. In Change Request (CR) 3631, carriers were instructed not to allow payment for CPT code 99211 with or without modifier -25 if it is billed with a nonchemotherapy or chemotherapy drug infusion code or with diagnostic or therapeutic injection codes. This transmittal will update the E/M manual section indicating Medicare will pay for a medically necessary office/outpatient visit (when it meets a higher complexity level than CPT code 99211) billed on the same day as a drug administration service as specified. Modifier -25 must be appended to the E/M service to identify that a significant and separately identifiable E/M service (higher complexity than CPT code 99211) was performed. There are different effective dates for the chemotherapy and nonchemotherapy drug infusions codes from the therapeutic and diagnostic injection codes.

**NEW/REVISED MATERIAL**

**EFFECTIVE DATE: January 1, 2004 for chemotherapy and nonchemotherapy drug infusion codes; and January 1, 2005 for therapeutic and diagnostic injection codes. Effective date for definition of "new patient" and "physician" is upon receipt.**

**IMPLEMENTATION DATE: January 03, 2006**

*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 – *Only One Per Row.*

| R/N/D | Chapter / Section / SubSection / Title |
|---|---|

| | |
|---|---|
| R | 12/30.6.7/Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215) |

**III. FUNDING:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

**IV. ATTACHMENTS:**

Business Requirements

Manual Instruction

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

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 731 | Date: October 28, 2005 | Change Request 4032 |
|---|---|---|---|

**SUBJECT: Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 – 99215)**

## I. GENERAL INFORMATION

**A. Background:** Clarification and correction is needed in Publication 100-04, Medicare Claims Processing Manual, Chapter 12, §30.6.7 for the definition of "new patient" and "physician" for same day E/M services to a patient for evaluation and management (E/M) visits paid by Medicare. Effective January 1, 2004, CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code. In the Physician Fee Schedule Final Rule, dated November 15, 2004, this policy was expanded to also include therapeutic and diagnostic injection codes. The addition of these injection codes was included in the instruction in Transmittal 129, dated December 10, 2004, Change Request (CR) 3631, with an effective date of January 1, 2005.

**B. Policy:** Clarification of the definition of "new patient" and "physician" for same day E/M services to the same patient for Medicare E/M payment policy is provided in section A and B. As stated in section D, CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code, or therapeutic or diagnostic injection code. There are two different effective dates of service for the policy on chemotherapy and nonchemotherapy drug infusion codes and therapeutic and diagnostic injection codes. Medicare will pay for a medically necessary higher level office/outpatient visit billed on the same day as a drug administration service with modifier -25 appended to the E/M code. The modifier will identify that a significant and separately identifiable evaluation and management (E/M) service, which meets a higher complexity level of care than a service represented by CPT code 99211, is performed.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*
*"Should" denotes an optional requirement*

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 4032.1 | Carriers shall interpret the phrase "new patient" to mean a patient who has not received any professional service (i.e., E/M service or other face-to-face service) from the physician or | | | X | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | physician group practice (i.e., same physician specialty) within the previous 3 years. | | | | | | | | | |
| 4032.2 | Carriers may not pay for two E/M office visits or other E/M 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.<br>Use Claim Adjustment Reason Code 18 – Duplicate claim/service with the following Remittance Advice reason code M86 – Service denied because payment already made for same/similar procedure within set time frame and line item remark code N20 - Service not payable with other service rendered on the same date. | | | X | | | | | | |
| 4032.3 | Effective January 1, 2004, contractors shall not pay for CPT code 99211 when reported with or without CPT modifier -25, with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code.<br>Effective January 1, 2005, contractors shall not pay for CPT code 99211 when reported with or without CPT modifier -25, with a therapeutic or diagnostic injection code.<br>Use MSN 16.8 – Payment is included in another service received on the same day.<br>Use Remittance Advice reason code 97 – Payment is included in the allowance for another service/procedure.<br>Use line item remark code N20 – Service not payable with other service rendered on the same date. | | | X | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 4032.4 | Effective January 1, 2004, contractors shall pay for a medically necessary, significant and separately identifiable E/M service which meets a higher complexity level than CPT code 99211 when performed on the same day of service with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code. Effective January 1, 2005, contractors shall pay for a medically necessary, significant and separately identifiable E/M service which meets a higher complexity level than CPT code 99211 when performed on the same day of service with a therapeutic or diagnostic injection code. CPT modifier -25 must be appended to the E/M service. | | | X | | | | | | |

## III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 4032.5 | A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. 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 | | | X | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | | | | | | | | | |

## IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

### A. Other Instructions: N/A

| X-Ref Requirement # | Instructions |
|---|---|
| | |

### B. Design Considerations: N/A

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---|---|
| | |

### C. Interfaces: N/A

### D. Contractor Financial Reporting /Workload Impact: NA

**E. Dependencies:** Transmittal 129, 2005 Drug Administration Coding Revisions, dated December 12, 2004, Change Request 3631

### F. Testing Considerations: N/A

## V. SCHEDULE, CONTACTS, AND FUNDING

| | |
|---|---|
| **Effective Date*:** January 1, 2004 for chemotherapy and nonchemotherapy drug infusion codes; January 1, 2005 for therapeutic and diagnostic injection codes. Effective date for definition of "new patient" and "physician" is upon receipt.<br><br>**Implementation Date:** January 3, 2006<br>**Pre-Implementation Contact(s):** Kit Scally (Cathleen Scally@cms.hhs.gov)<br><br>**Post-Implementation Contact(s):** Appropriate Regional Office staff | No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets. |

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

# Medicare Claims Processing Manual
## Chapter 12 - Physicians/Nonphysician Practitioners

**Table of Contents**

***(Rev.731, 10-28-05)***

## 30.6.7 - Payment for Office *or Other* Outpatient Evaluation and Management (*E/M*) Visits (Codes 99201 - 99215)

***(Rev.731, Issued: 10-28-05, Effective: 01-01-04 Chemotherapy and Non-Chemotherapy drug infusion codes/01-01-05 Therapeutic and Diagnostic injection codes, Implementation: 01-03-06)***

**A - Definition of New Patient for Selection of *E/M* Visit Code**

*Interpret the phrase* "new patient" to mean a patient who has not received any professional services, *i.e., 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 3 years. For example, if a professional component of a previous procedure is billed in a 3 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.

**B - Office/Outpatient *E/M* Visits Provided on Same Day for Unrelated Problems**

*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).

**C - Office/Outpatient or Emergency Department *E/M* Visit on Day of Admission to Nursing Facility**

Carriers may not pay a physician for an emergency department visit or an office visit **and** a comprehensive nursing facility assessment on the same day. Bundle *E/M visits* on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician.

**D – *Drug Administration Services and E/M Visits Billed on Same Day of Service***

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 nonchemotherapy drug infusion code (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 15, 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.*