

Multiple E/Ms on the Same Day

Rules Committee Recommendation

Multiple E/Ms on the Same Day reporting rule

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Modifier Involved

Current Procedural Terminology (CPT®)¹ or HCPCS modifiers that apply.

Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

Multiple E/Ms on the Same Day rule

This edit identifies when multiple E/M services are billed on the same day by the same provider. Except when the criteria are met and the appropriate modifier is appended, only one E/M may be eligible for reimbursement.

Additional correct coding edits for reporting E/M services exist. This rule addresses reporting multiple E/M services for the same date of service by the same provider.

Coding and adjudication guidelines

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Rules governing the reporting of more than one E/M code reported for a patient on the same date of service by the same provider are very complex and are not described in their entirety herein. However, the NCCI contains numerous edits based on several principles including, but not limited to:

1. A physician may report only one “new patient” encounter on a single date of service. That encounter may include more than one E/M code when significant, separately identifiable services are performed during a visit for both a preventive E/M and a problem-oriented E/M. One new patient code for the preventive exam AND one new patient code for the problem-oriented E/M may be submitted for the same encounter. Modifier 25 must be appended to the problem-oriented E/M code.
2. A physician may report only one code from a range of codes describing an “initial” E/M service on a single date of service. Modifier override is not allowed.
3. A physician may report only one “per diem” E/M service from a range of per diem codes on a single date of service. Modifier override is not allowed.
4. A physician should not report an “initial” per diem E/M service with the same type of “subsequent” per diem service on the same date of service. Modifier override is not allowed.
5. E/M codes describing observation/inpatient care services with admission and discharge on same date should not be reported on the same date of service as initial hospital care per diem codes subsequent hospital care per diem codes or hospital discharge day management codes. Modifier override is not allowed.

Preventive medicine and problem-oriented E/M visits

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

For example, if the patient makes an appointment for a routine physical and is asymptomatic at the time of the encounter, discussion of chronic problems and medication refills are an expected part of the exam – not something extra that can be billed. If the patient is asymptomatic, there is no chief complaint to support anything beyond the well visit.

If the patient makes an appointment for a routine physical and upon presentation expresses a symptomatic problem, there is a chief complaint and a problem-oriented E/M may be reported.

Office/outpatient problem-oriented E/M visits for unrelated problems

More than one E/M visit should be reported by a physician for the same patient on the same day **ONLY** when 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). The physician must document that the visits were for unrelated problems.

Hospital admission (inpatient or observation status) following an encounter in another site

If a patient is admitted to the hospital in the course of an encounter in another site of service (e.g., emergency department, observation status changing to inpatient admission in a hospital, office, nursing facility), all E/M services provided by a physician in conjunction with the admission are considered part of the initial hospital care, when performed on the same date as the admission. A separate code for the E/M services in the other site is not reported. The initial hospital care level of service reported by the admitting physician should include the services related to the admission provided in other sites of service, as well as the E/M services the physician provided on that same date in the inpatient setting.

If a patient is admitted to a hospital after an outpatient consultation, and the patient is not seen on the unit on the date of admission, only the outpatient E/M code is reported.

Critical care services and other E/M services

When critical care services are required upon the patient's presentation to the hospital emergency department, only critical care E/M codes may be reported. An emergency department visit code may not also be reported by the same physician.

When critical care services are provided on a date where an inpatient hospital or office/outpatient E/M service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous E/M services may be reported, with the exception of emergency department E/M services. Modifier 25 must be appended to the code with the lower RVU. Payers may require documentation to support the claims for both services.

Critical care services provided by physicians in group practice

Physicians in the same group practice who have the same specialty may not each report CPT initial critical care on the same calendar date, but must bill and be paid as though each were the single physician. Two or more physicians of the same group practice who have different specialties and who provide critical care services may each report the initial critical care code on the same date when the care rendered is unique to each specialty. However, if a physician of qualified NPP within a group provides "staff coverage" or "follow-up" for each other after the first hour of critical care services was provided on the same calendar date by the previous group clinician, the subsequent visits by the "covering" physician or qualified NPP in the group will be billed using the CPT code for subsequent critical care services.

NOTE: Prolonged services are add on codes that should be reported with an E/M code.

Split bills

A split/shared service is an encounter where a physician and a non-physician practitioner NPP each personally perform a portion of an E/M visit. Two E/M's are not reported. See the CMS Manual for further instructions.

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual² were selected.

MCCTF comment

Includes all services provided on the date of admission in other sites of service (eg, emergency department, office, nursing facility) (99201-99215, 99281-99285, 99304-99318, 99324-99337, 99341-99350, 99381-99397)

Includes initial physician services provided to the patient in the hospital or "partial" hospital settings (99221-99223) Physician services provided to the patient observation status on the same date as inpatient E & M service.

Edit/Modifier definitions

This edit identifies when multiple E/Ms are billed on the same day by the same provider. Except when the above criteria are met and the appropriate modifier is appended, only one E/M may be eligible for reimbursement. However, the following services can be separately reported on the same day as other procedures: E/M, prolonged, preventive, disability evaluation, and critical services.

Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Additional definitions

NA

² Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

Federation outreach

- American Academy of Orthopaedic Surgeons (AAOS)
- American Academy of Otolaryngology – Head and Neck Surgery
- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American Congress of Obstetricians and Gynecologists (ACOG)
- College of American Pathologists (CAP)
- The AMA Federation Payment Policy Workgroup

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