Evaluation and management FAQs

2021 office E/M changes

Consults

Critical care

Emergency room

Observation

General evaluation and management (E/M)

- Coding
- Documentation
- Key components (history, exam, MDM, time)

Home

Inpatient visits (initial, subsequent, discharge day management)

Nursing facility

Office

Incident to

2021 office E/M changes

Need Help?

1. **Where can the CPT E/M code and guideline changes for 2021 be found?**

The CPT E/M code and guideline changes for 2021 can be found in the American Medical Association (AMA) CPT® E/M office or other outpatient (99202-99215) and prolonged services (99354, 99355, 99356, 99XXX) code and guideline changes for 2021 .

2. **Where can the revised medical decision-making table for 2021 be found?**

The revised medical decision-making table can be found in the AMA Table 2 - CPT® E/M office revisions level of medical decision making (MDM) .

3. **There are 22 new definitions in the CPT E/M changes for 2021. Where can the 22 new definitions be found?**

The new definitions can be found in the AMA CPT® E/M code and guideline changes for 2021 .

4. **Can we still bill 99201-99205 and 99211-99215 based on the 1995 and 1997 guidelines for dates of service on and after January 1, 2021?**

Office/outpatient visits prior to January 1, 2021, may still be billed using the 1995 or 1997 guidelines. Providers must bill office/outpatient visits provided **on or after** January 1, 2021 using the CPT E/M code and guideline changes for 2021.

Note: Based on the CPT changes, code 99201 is no longer valid for dates of service on and after January 1, 2021.

Reference

AMA CPT® E/M code and guideline changes for 2021

5. **Does the 2021 E/M code and guideline changes apply to all categories of E/M services?**

No. The E/M code and guideline changes are specific for office and other outpatient visits and apply to codes 99201–99205 and 99211–99215.

Note: Based on the CPT changes, code 99201 is no longer valid for dates of service on and after January 1, 2021.

Reference

AMA CPT® E/M code and guideline changes for 2021

6. **For dates of service on and after January 1, 2021, how are the levels of E/M services provided in an office/outpatient setting determined?**

Effective for dates of service on and after January 1, 2021, you would select the appropriate level of E/M service based on the following:

- The level of the medical decision making as defined for each service; or
- The total time for the E/M service performed on the date of the encounter.

7. **Does the revised medical decision-making table for 2021 provided by the AMA apply to all E/M services?**

No. The CPT E/M code and guideline changes for 2021 and subsequent MDM table only apply to office/outpatient E/M services beginning January 1, 2021. All other E/M categories and codes continue to follow the 1995 and/or 1997 E/M guidelines.

Reference

AMA Table 2 - CPT® E/M office revisions level of MDM

8. **Is the documentation of history and examination required when scoring office/outpatient services under the revised 2021 guidelines?**

The approved revisions do not materially change the three current MDM elements, but instead provide extensive edits to the elements for code selection and revised or created numerous clarifying definitions in the E/M guidelines.

While the provider's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level.

The revised code descriptors state a "medically appropriate history and/or examination" is required.

Reference

AMA CPT® E/M code and guideline changes for 2021

9. **Is time defined differently for office and outpatient E/M services effective for dates of service on and after January 1, 2021?**

For dates of service on and after January 1, 2021, time is defined as minimum time, not typical time, and represents the total physician or other qualified health care professional time on the date of service. The use of 'date-of-service time' builds on the movement over the last several years by Medicare to better recognize the work involved in non-face-to-face services, like care coordination.

This definition applies only when code selection is based on time and not MDM.

Reference

AMA CPT® E/M code and guideline changes for 2021

10. **When coding by time, is the day of encounter by calendar date or 24-hour period?**

When coding by time, only the time spent on the actual date of the encounter is applicable .

Reference

AMA CPT® E/M code and guideline changes for 2021

11. **How is time counted under the CPT E/M code and guideline changes for 2021?**

Except for code 99211, per AMA, beginning with CPT changes 2021, time alone may be used to select the appropriate code level for the office or other outpatient E/M service codes (99202-99205, 99212- 99215).

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service.

When time is used to select the appropriate level for E/M service codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health professional.

For office or other outpatient services, if the physician's or other qualified health professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use code 99211.

Reference

AMA CPT® E/M code and guideline changes for 2021

12. **What activities are included in physician's time?**

Physician/other qualified health care professional time includes the following activities when performed:

- Preparing to see the patient (e.g., review of tests).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling and educating the patient/family/caregiver.
- Ordering medications, tests, or procedures.
- Referring and communicating with other health care professionals (when not separately reported).
- Documenting clinical information in the electronic or other health record.
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.
- Care coordination (not separately reported).

13. **Does Novitas have a score sheet based on the CPT E/M guideline changes for 2021?**

Effective for dates of service on and after January 1, practitioners will have the choice to document office/outpatient E/M visits via MDM or time. CMS is adopting the AMA's revised CPT guidance, including deletion of CPT code 99201. The E/M code and guideline changes are specific for office and other outpatient visits and apply to codes 99201–99205 and 99211–99215. Based on the CPT changes, code 99201 is no longer valid for dates of service on and after January 1, as clinicians may choose the E/M visit level based on either medical decision making or time; both CPT code 99201 and 99202 require straightforward medical decision making, therefore the decision was made to delete CPT code 99201.

To assist providers with this change, the E/M interactive score sheet (JH)(JL) has been updated. The updated score sheet will function based on the date of service and type of visit. If the date of service is on and after January 1, and related to an office or outpatient services visit, the score sheet options

will align with the AMA guidance to determine the level of E/M service performed. If not related to office or outpatient services, or the date of service is prior to January 1, the score sheet options will remain based on the 1995 guidelines. Helpful resources and tips will be available within the tool as an added resource to guide providers in determining the level of E/M service.

14. **How do other requirements (e.g., teaching physician, incident to, new vs. established) apply when using the CPT E/M guidelines for 2021?**

CMS is adopting the AMA's guidance on coding office/outpatient E/M visits. Most rules remain unchanged.

15. **Can the independent visualization of a test be counted in the medical decision making if the physician is also billing for the test?**

Per AMA, the ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (e.g., tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation but may be counted as ordered or reviewed for selecting an MDM level. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of MDM. For more information, please review the AMA CPT® E/M code and guideline changes for 2021 .

16. **When auditing MDM, is there a list of drugs considered "drug therapy requiring intensive monitoring for toxicity?"**

CMS itself has not provided such a list for use with the 1995 or 1997 guidelines. This question is answered in the CPT changes for 2021:

"Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient. Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold."

For more information, please review the AMA CPT® E/M code and guideline changes for 2021 .

Consultations

Medicare no longer recognizes consultation codes (99241-99245 and 99251-99255). Physicians shall code patient evaluation and management (E/M) visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed.

For additional guidance, consider taking one of our E/M web-based training courses or join us for one of our informative E/M webinars (JH)(JL).

Critical care

1. **NPP sees patient at 9 a.m. and records 90 minutes of critical care then MD sees the patient at 2 p.m. and records 25 minutes of critical care services. They are in the same group practice. Would we post 99291 and 99292, or just one 99291?**

This would be considered split/shared and the time would be aggregated for a total of 115 minutes so you would bill 99291 and 99292 for the NPP since they are performing the substantive portion with the FS modifier.

Reference

CMS IOM Pub. 100-04, Medicare Claims Processing Manual Chapter 12, section 30.6.12.5

2. **If the MD and NPP are part of the same group, if they are in the room together with the patient, we can only count that time once, correct?**

Yes, this situation would be considered split/shared and the time together can only be counted once. Consistent with all split/shared visits, when two or more practitioners spend time jointly meeting with or discussing the patient as part of a critical care service, the time can be counted only once for purposes of reporting the split (or shared) critical care visit.

Reference

CMS IOM Pub. 100-04, Medicare Claims Processing Manual Chapter 12, section30.6.12.5

3. **To clarify, if a physician sees a patient for critical care for 20 minutes, runs to see another patient for 10 minutes and then back to the critical care patient for 40 minutes, you can still charge the 99291?**

For 99291, it does not have to be continuous, but it does require the full attention of the provider. So yes, 20 minutes plus 40 minutes would be a total of 60 minutes which would meet the definition of 99291 which is 30 - 74 minutes.

Reference

CMS IOM Pub. 100-04, Medicare Claims Processing Manual Chapter 12, section 30.6.12.1

4. **When documenting the time, I know the providers can do total time or start/stop times. If they chose to document total time, it has to be the specific number of minutes? Not just "greater than 35 minutes"?**

Critical care is a time-based service. The provider must document in the medical record the total time (not necessarily start and stop times).

Reference

CMS IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 30.6.12.8

5. **Do you also use modifier 24 with FT when critical care is unrelated to the surgery during a global surgery?**

No, modifier FT would be used for critical visits that are unrelated to the surgical procedure but performed on the same day; or when critical care services provided during a global surgical period are unrelated to a surgical procedure.

For additional guidance, please review our article on critical care services.

Reference

CMS IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 30.6.12.7

General E/M services

Coding

1. **If a physician sees a patient in the office in the morning for a new condition and again in the afternoon because the condition has worsened, should modifier -25 be appended the afternoon visit?**

No. The physician would be expected to combine the documentation and bill only one E/M. Modifier -25 is used to identify a significantly, separately identifiable E/M service performed by a physician on the same date as a procedure or other service.

2. **In rare circumstances, would a physician bill a second E/M service on the same date of service for the same patient?**

If a second E/M service is required on the same date of service, the documentation should clearly provide evidence of the second E/M service occurring, the reason for the additional E/M service, and documentation of the medical necessity of the second E/M service. When reporting a second E/M service on the same date, the service will initially deny as only one E/M is reimbursable per day, per patient, per physician or same group, same specialty You may appeal the denial with documentation. Novitas Solutions would not expect to see two E/M services reported on the same date on a routine basis. Information on the appeals process is available in the Part B Appeals Reference Guide.

3. **How do you bill e/m's performed on the same day as other services?**

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).

E/M services 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 major surgery; see modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

For more information and proper usage of modifier 25, please refer to Modifier 25 Fact Sheet and Modifier 25 Tips.

4. **How does Novitas review an E/M billed with modifier -25?**

Modifier -25 is used to report significant and separately identifiable E/M services by the same physician on the same day of the procedure or other service. In the review of E/M services billed with the -25 modifier, we will first identify within the medical records the documentation specific to the procedure or service performed on that date of service. We also consider the additional documentation for the additional service separate from the documentation specific to the initial procedure or service to determine:

- If there is a significant, separately identifiable E/M service that was rendered and documented, and
- If the required components of the E/M service are supported as "reasonable and necessary" per Social Security Act, Section 1862(a)(1)(A), and
- If the level of care is supported by the documentation contained in the medical records.

5. **Can two physicians in the same group practice, who see the same patient on the same day, each bill for an E/M service and receive payment?**

Physicians in the same group practice but who are in different specialties may bill and be paid separately without regard to their membership in the same group.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Reference

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.5

6. **How is the AI modifier used?**

The principal physician of record appends modifier "-AI" to their initial hospital care visit code. This modifier identifies the physician who oversees the patient's care from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient bill without the "-AI" to indicate specialty care.

This modifier is informational only. It does not affect reimbursement. Claims which include the "-AI" modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.

7. **Can we append modifier 25 to 99211?**

No, it is not appropriate to append modifier 25 to 99211. According to CMS, it is appropriate to append modifier -25 when the modifier indicates that a separately identifiable E/M service was performed that meets a higher complexity level of care than a service represented by 99211.

Reference

CMS IOM Pub. Claims Processing Manual, Chapter 12, section 30.6.6

8. **If a physician moves from one group practice to another, can the physician bill the patients as new if they go to the new practice?**

The provider would not be able to bill previously seen patients as a new patient unless he meets the three-year guideline for a new patient visit.

A new patient is defined as a patient who has not received any professional services, i.e., E/M services or other face-to-face services from the physician or physician group practice within the previous three years.

Reference

CMS IOM Pub. Medicare Claims Processing Manual Chapter 12, section 30.6.7

9. **Is it acceptable to score a 99215 if the medical decision making is low?**

For dates of service prior to January 1, 2021, the level of established patient visits is scored by using the highest 2 key components. The medical decision making (MDM) drives the amount of work conducted during the encounter. A low MDM may not support the necessity of a comprehensive history and a comprehensive exam.

For example, the medical appropriateness of a comprehensive history and comprehensive exam could be questioned for an established patient encounter if the patient is prescribed an over-the-counter medication such as Tylenol.

Note: Effective January 1, 2021, for office/outpatient E/M visits, the 1995 and 1997 E/M guidelines will no longer be used. Practitioners will have the choice to document office/outpatient E/M visits using medical decision making (MDM) or time. For further guidance, see the AMA CPT E/M office visit revisions and the AMA Table: CPT E/M Office Revisions - Medical Decision Making (MDM).

10. **In E/M, if the provider does not do an exam on the patient, how do we code?**

Depending on the category of E/M, the level of service would be based on the components documented. If time is an element documented and the physician documents more than half of the time was spent counseling and/or coordinating care, the level of service would be based on time.

Note: Effective January 1, 2021, for office/outpatient E/M visits, the 1995 and 1997 E/M guidelines will no longer be used. Practitioners will have the choice to document office/outpatient E/M visits using medical decision making (MDM) or time. For further guidance, see the AMA CPT E/M office visit revisions and the AMA Table: CPT E/M Office Revisions - Medical Decision Making (MDM).

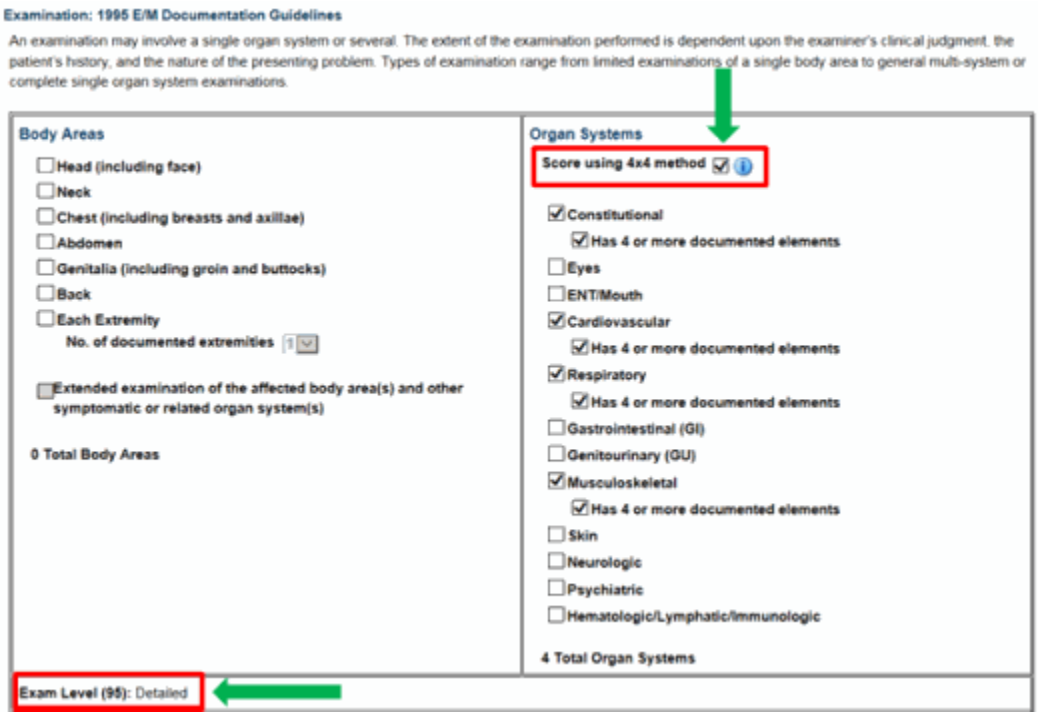
11. **How can I score a detailed exam using the interactive score tool?**

The interactive score sheet will allow you to score a detailed exam only if using the 4x4 method. You must check off the box "Score using 4x4 method". See the image below.

When reviewing a medical record and scoring the exam, our medical staff will automatically score a detailed exam if 4 or more exam items are noted in the medical record for 4 or more body areas or organ systems. However, less than such can still be a detailed exam based on the reviewer's clinical judgment, which is considered clinical inference.

Our nurse reviewers also use their clinical knowledge while reviewing medical record documentation to determine the correct and appropriate level of care. It provides for an individual consideration and makes the review of all services (including E/M examinations) fairer to the physician.

Clinical inference overrides the 4x4 method; and is consistent with CMS instructions for reviewing all medical records.



12. **Using the 4x4 method, would 16 items between the documented organ systems meet the requirement? For instance, can a detailed exam be given if constitutional has 4 elements, cardiovascular has only 2 elements documented, respiratory has 6 elements, and GI has 4 elements.**

When reviewing a medical record and scoring the exam, the interactive score sheet will automatically score only a detailed exam if 4 or more exam items are noted in the medical record for 4 or more body areas or organ systems. However, less than such can still be a detailed exam based on the reviewer's clinical judgment, which is considered clinical inference. For more information, review the 4x4 method article.

Documentation

1. **If we are using the 1997 evaluation and management guidelines for the examination component, do we have to use the 1995 guidelines for the history and medical decision-making components?**

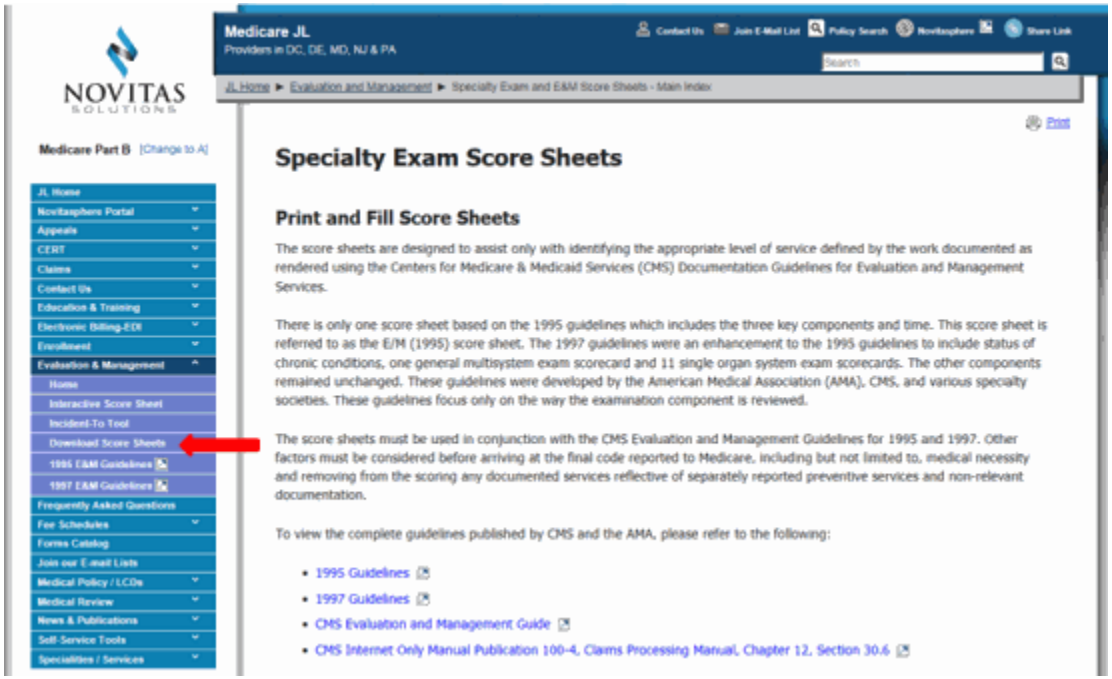
The history and medical decision making from the 1995 guidelines are used with both the 1995 and the 1997 guidelines. The 1997 guidelines provide the specialty examination guidelines only. The 1997 guidelines enhanced the history component by adding a status of chronic conditions.

2. **How is medical necessity considered when scoring medical records?**

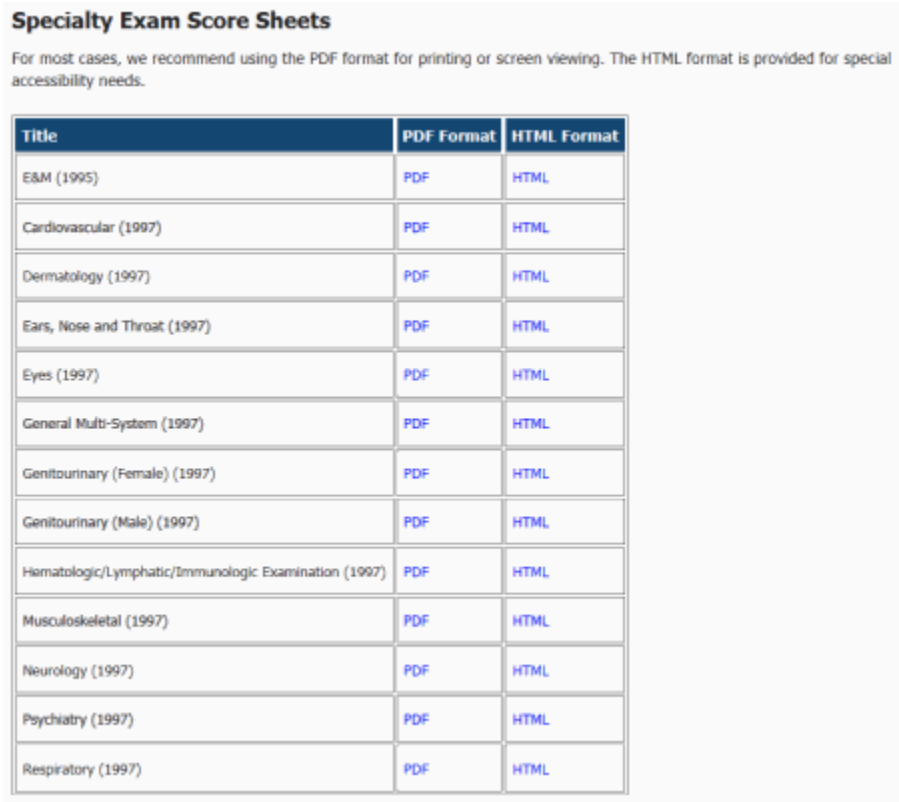
All services under Medicare must be reasonable and necessary as defined in Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section states, "…no payment may be made for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of injury or to improve the functioning of a malformed body member." Therefore, medical necessity is the first consideration in reviewing all services.

3. **Where can I find E/M specialty score sheets on the Internet?**

You can find the E/M specialty score sheets on the Evaluation & Management dropdown tab on the left navigation of our website.


NOVITAS
SOLUTIONS
Medicare Part B [Change to A]
JL Home
Novitasphere Portal
Appeals
CERT
Claims
Contact Us
Education & Training
Electronic Billing-EDI
Enrollment
Evaluation & Management
Home
Interactive Score Sheet
Incident-To Tool
Download Score Sheets
1995 E&M Guidelines
1997 E&M Guidelines
Frequently Asked Questions
Fee Schedules
Forms Catalog
Join our E-mail Lists
Medical Policy / LCDs
Medical Review
News & Publications
Self-Service Tools
Specialties / Services
Medicare JL
Providers in DC, DE, MD, NJ & PA
Contact Us
Join E-Mail List
Policy Search
Novitasphere
Share Link
Search
JL Home ► Evaluation and Management ► Specialty Exam and E&M Score Sheets - Main Index
Print
Specialty Exam Score Sheets
Print and Fill Score Sheets
The score sheets are designed to assist only with identifying the appropriate level of service defined by the work documented as rendered using the Centers for Medicare & Medicaid Services (CMS) Documentation Guidelines for Evaluation and Management Services.
There is only one score sheet based on the 1995 guidelines which includes the three key components and time. This score sheet is referred to as the E/M (1995) score sheet. The 1997 guidelines were an enhancement to the 1995 guidelines to include status of chronic conditions, one general multisystem exam scorecard and 11 single organ system exam scorecards. The other components remained unchanged. These guidelines were developed by the American Medical Association (AMA), CMS, and various specialty societies. These guidelines focus only on the way the examination component is reviewed.
The score sheets must be used in conjunction with the CMS Evaluation and Management Guidelines for 1995 and 1997. Other factors must be considered before arriving at the final code reported to Medicare, including but not limited to, medical necessity and removing from the scoring any documented services reflective of separately reported preventive services and non-relevant documentation.
To view the complete guidelines published by CMS and the AMA, please refer to the following:
1995 Guidelines
1997 Guidelines
CMS Evaluation and Management Guide
CMS Internet Only Manual Publication 100-4, Claims Processing Manual, Chapter 12, Section 30.6

Need Help?



Specialty Exam Score Sheets

For most cases, we recommend using the PDF format for printing or screen viewing. The HTML format is provided for special accessibility needs.

Title	PDF Format	HTML Format
E&M (1995)	PDF	HTML
Cardiovascular (1997)	PDF	HTML
Dermatology (1997)	PDF	HTML
Ears, Nose and Throat (1997)	PDF	HTML
Eyes (1997)	PDF	HTML
General Multi-System (1997)	PDF	HTML
Genitourinary (Female) (1997)	PDF	HTML
Genitourinary (Male) (1997)	PDF	HTML
Hematologic/Lymphatic/Immunologic Examination (1997)	PDF	HTML
Musculoskeletal (1997)	PDF	HTML
Neurology (1997)	PDF	HTML
Psychiatry (1997)	PDF	HTML
Respiratory (1997)	PDF	HTML

4. **Is it acceptable to use abbreviations in the patient's medical record?**

Abbreviations may be used in the patient's medical record. If your patients' medical records contain abbreviations not commonly used, and you receive a request for medical records, please provide a key to the abbreviations. Submit the key with the medical records to assist us in the review.

Key components

History

1. **What parts of the history can be documented by ancillary staff or the beneficiary starting in CY 2019?**

Per CMS, the CY 2019 PFS final rule expanded current policy for office/outpatient E/M visits starting January 1, 2019, to provide that any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the beneficiary does not need to be re-documented by the billing

practitioner. Instead, when the information is already documented, the billing practitioner can review the information, update or supplement it as necessary, and indicate in the medical record that she or she has done so. This is an optional approach for the billing practitioner and applies to the CC and any other part of the history (history of present illness (HPI), past family social history (PFSH), or review of systems (ROS) for new and established office/outpatient E/M visits.

To clarify terminology, we are using the term "history" broadly in the same way that the 1995 and 1997 E/M documentation guidelines use this term in describing the CC, ROS and PFSH as "components of history that can be listed separately or included in the description of HPI." This policy does not address who can independently take/perform histories or what part(s) of history they can take, but rather addresses who can document information included in a history and what supplemental documentation should be provided by the billing practitioner if someone else has already recorded the information in the medical record.

Reference

Evaluation and Management (E/M) Visit Frequently Asked Questions (FAQs) Physician Fee Schedule (PFS)

2. **What is "status of chronic conditions"?**

The 1997 Guidelines enhanced the HPI section of the 1995 score sheet to include the patient's chronic conditions the practitioner is following or in which an exacerbation may have occurred resulting in the chief complaint and the reason for the patient encounter. The documentation in the patient's medical record must clearly state a status of the chronic condition in order to meet the requirement under the HPI status of 1, 2, or 3 chronic conditions on the 1995 score sheet. An example could be hypertension - stable on Atenolol.

3. **If the physician states same/unchanged from last visit, will he receive credit for reviewing the last visit information?**

Yes, only if the physician includes the documentation from the previous visit. Otherwise, the reviewer would not know what was the same or unchanged from the previous visit.

4. **For the review of systems (ROS), can the physician reference a sheet that he has in the patient's chart where the physician checked off items?**

Yes. However, the physician must include the sheet with all documentation for that date of service if he/she receives a request for medical records. Otherwise, the physician will not receive credit for the information on the check-off sheet.

Note: Effective January 1, 2021, for office/outpatient E/M visits, the 1995 and 1997 E/M guidelines will no longer be used. Practitioners will have the choice to document office/outpatient E/M visits using medical decision making (MDM) or time. For further guidance, see the AMA CPT E/M office visit revisions and the AMA Table: CPT E/M Office Revisions - Medical Decision Making (MDM) .

5. **Our office requests our patients complete a form regarding medication use, medical history, family history, and social history information. Can this information be included as documentation of the PFSH and ROS?**

Yes, you may use this information. For the physician to receive credit for the information, the form must be included in the patient's record for the encounter is medical documentation is requested. It is also appropriate for the physician to note in the medical records any additional information obtained during the face-to-face encounter.

Note: Effective January 1, 2021, for office/outpatient E/M visits, the 1995 and 1997 E/M guidelines will no longer be used. Practitioners will have the choice to document office/outpatient E/M visits using medical decision making (MDM) or time. For further guidance, see the AMA CPT E/M office visit revisions and the AMA Table: CPT E/M Office Revisions - Medical Decision Making (MDM) .

6. **Can the patient's past medical history be used in scoring the ROS or HPI elements?**

No. The ROS and HPI elements pertain to the chief complaint and the reason for the patient's visit that day, not past medical history information.

7. **When scoring the ROS, can the systems addressed in the HPI elements be used or is that "double dipping"?**

ROS inquiries are questions concerning the system(s) directly related to the problem(s) identified in the HPI. Therefore, it is not considered "double dipping" to use the system(s) addressed in the HPI for ROS credit.

8. **Under limited circumstances, could we use "noncontributory" as appropriate documentation to support the family history section of the history component of an E/M?**

There may be circumstances where the term "noncontributory" may be appropriate documentation when referring to a patient's family history during an E/M visit if the family history is not pertinent to the presenting problem.

9. **How can we determine the difference between modifying factors and associated signs and symptoms?**

A modifying factor is something done to help or alleviate the problem (i.e., "took two nitroglycerin tabs with no relief").

Associated signs and symptoms are signs and symptoms that are associated or related to the presenting problem (i.e., shortness of breath and nausea).

10. **When a physician performs an E/M service and the patient is not able to provide history, if the physician documents "patient in a coma," "patient not able to respond," "patient unresponsive," can they count a comprehensive history?**

When a physician performs an E/M service and is unable to obtain parts of the history component for that encounter, documentation should clearly reflect the components that were not obtained (HPI, ROS and/or PFSH). Documentation should also include why the components were not obtained (patient unresponsive, sedate on a vent, etc.), and attempts to obtain information from other sources, such as a family member, spouse, nurse, etc. When the clinical reviewers are reviewing documentation, it is reviewed in its entirety. If the documentation clearly supports that the patient is not able to provide the information necessary (history components) and attempts were made to obtain the history from other sources, a comprehensive history level may be credited.

References

1995 Documentation Guidelines for Evaluation and Management Services

1997 Documentation Guidelines for Evaluation and Management Services

Exam

1. **Under the examination section of the 1995 score sheet, can we combine the body areas and organ systems?**

No. The examination section of the 1995 score sheet is divided into body areas and organ systems. The CPT manual recognizes 7 body areas and 12 organ systems. Depending on the documentation in the patient's medical record, you can use either the body areas or the organ systems. There is a dotted line between the body areas and organ systems indicating you must choose one or the other. If you combined the body areas and organ systems, you would be giving credit twice, which would be incorrect when determining the final score for the examination section of the score sheet. An example could be the documentation in the patient's medical record stated abdomen soft, credit can only be given in the body areas under abdomen or in the organ systems under gastrointestinal, which ever area benefited the physician the most with scoring.

2. **Do body areas of the examination section of the 1995 score sheet work exactly as the organ systems?**

You may count up to 7 body areas or 7 organ systems for an expanded problem focused or detailed examination and you may count 8 body areas or 8 organ systems for a comprehensive examination. However, you may not add body areas and organ systems together to determine the level of the examination.

Medical decision making using 1995 and 1997 guidelines

1. **How do we get credit for a test under the amount and/or complexity of data reviewed section of the E/M score sheet?**

You can get credit in this section when the test (clinical lab test, test in the radiology section of CPT, or test in the medicine section of CPT) is documented as reviewed and/or ordered, and the service is medically indicated. The maximum number of tests credited in each section is one.

2. **What constitutes additional workup in the amount and complexity of data grid for medical decision making?**

The number of possible diagnoses and/or the number of management options considered is on the number of types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions made by the physician. For each encounter, you should document an assessment clinical impression or diagnosis. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

Additional workup in all settings is work done beyond the encounter when the physician needs to obtain more information for his medical decision-making and the results will be received when the patient is no longer present.

For example, additional work up would be if a physician sees a patient in his office, writes an order for lab tests and the results will be received requiring further evaluation when the patient is no longer present.

3. **If I personally review a film, e.g., x-ray, electrocardiogram in my office, will I receive 2 points on the E/M score sheet?**

Two points may be given in amount and/or complexity of data reviewed when a practitioner independently visualizes an image, tracing or specimen previously or subsequently interpreted by another physician. The medical record documentation must clearly indicate that the physician/qualified NPP personally (independently) visualized and performed the interpretation of the image, tracing, or specimen. Credit will not be given if the documentation reveals the practitioner only read/reviewed a report from another physician/qualified NPP.

If the same practitioner performing the E/M service is also billing separately for the professional component of a test in the radiology and/or medicine section of the CPT, two points should not be credited for independent visualization of the same image, tracing or specimen.

In addition, the practitioner cannot take credit for review and/or order and independent visualization of the same test during the same encounter.

4. **When can prescription drug management be credited in the medical decision-making risk of complications chart?**

Credit is given for prescription drug management when documentation indicates medical management of the prescription drug by the physician who is rendering the service. Medical management includes a new drug being prescribed, a change to an existing prescription or simply refilling a current medication. The drug and dosage should be documented as well as the drug management.

If medications are just listed in patient's medical record, credit is given for past history.

Reference

1995 Documentation Guidelines for Evaluation and Management Services

5. **What do the terms 'new' or 'established' problem to the physician mean?**

The terms 'new' or 'established' problem to the examiner, which appear on the score sheet, refers to whether the patient's problem or chief complaint is new to the physician or established to the physician. Is this the first time the physician is seeing the patient for this problem, or is the physician currently treating or previously treated the patient for this problem?

6. **Can a provider who bills 93000 also use his interpretation in the medical decision-making section when selecting a level of E/M service; for instance, when the ECG is abnormal?**

If the provider performs and bills 93000 (professional and technical component), he cannot take credit for it in the E/M as the ECG includes an MDM component.

Time

1. **My patient visits are primarily counseling and coordination of care. How do I bill for this type of patient visit?**

When counseling and/or coordination of care dominate more than 50% of the time a physician spends with a patient during an E/M service then time may be considered as the controlling factor to qualify the E/M service for a particular level of care. If the physician elects to report the level of care based on counseling and/or coordination of care, then several factors must be in the patient's medical record. The following must be in the patient's medical record in order to report an E/M service based on time:

- The total length of time of the E/M visit.
- Evidence that more than half of the total length of time of the E/M visit was spent in counseling and coordinating of care; and
- The content of the counseling and coordination of care provided during the E/M visit.

Emergency room

1. **When a patient presents to an emergency department prior to midnight and the physician sees them after midnight, which date of service do we report?**

The date of service would be the date the physician performs a face-to-face service with the patient.

2. **If a patient is seen in the emergency department, then admitted to the hospital, how should this be billed?**

The CMS internet-only manual states A/B MACs (B) pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. They do not pay for both E/M services. Also, they do not pay for an emergency department visit by the same physician on the same date of service. When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.

Reference

CMS IOM Pub. 100-04 Claims Processing Manual, Chapter 12, section 30.6.9.1

Observation

1. **Should I appeal my denied observation claim?**

Initial observation care should be billed only by the physician who ordered hospital outpatient observation services and was responsible for the patient during his/her observation care. All other practitioners bill office/outpatient procedure codes. Prior to submitting an appeal, evaluate documentation to determine if a code change through a claim reopening is necessary.

References

CMS IOM Pub. 100-04 Claims Processing Manual, Chapter 12, section 30.6.8

Observation Fact Sheet

Home

1. **Does Medicare allow payment for E/M visits in a patient's home?**

Home services CPT codes 99341 through 99350 are used to report E/M services furnished to a patient residing in his or her own private residence (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted living facilities and group homes. The home services codes apply only to the specific 2-digit POS 12 (home). Home services codes may not be used for billing E/M services provided in settings other than the private residence of an individual as described above.

References

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.14

Home visits

2. **Can a podiatrist bill a home visit?**

Yes, as long as home visits are within the scope of practice and state licensure for podiatrists, and the service rendered is medically necessary.

Inpatient visits

1. **What is required to bill based on time in the inpatient setting?**

In an inpatient setting, time is defined as unit/floor time which includes time the physician spends on the patient's hospital unit as well as time spent at the patient's bedside rendering care. The average time for inpatient hospital care codes include the time in which the physician reviews the medical record, examines the patient, charts notes, and communicates with other professionals and the patient's family. It does not include time spent off the patient's floor.

- Key points for billing inpatient hospital care using time:
  - Encounter must be dominated by counseling and coordination of care.
  - More than 50 percent must be spent providing counseling or coordination of care.
- Counseling and/or coordination of care must be provided:
  - At the bedside; or
  - On the patient's hospital floor; or
  - On the unit that is associated with an individual patient.
- Documentation must include:

- Duration of counseling or coordination of care provided face-to-face on the floor; and
- Total duration of the visit.
- Extent of counseling and/or coordination of care must be documented in the medical record.

- May not count any time spent off the patient's floor/unit.
- Code selection is based on total unit/floor time.

Initial

1. **Will Medicare make payment for more than one initial hospital visit during the same admission performed by providers of the same specialty but different group practices?**

No, Medicare does not reimburse multiple visits to providers of the same specialty within the same and/or different group practices. Medicare will reimburse multiple visits to physicians from different groups and different specialties, or physicians of different specialties within the same group practice.

2. **Does Medicare allow an initial hospital care on a day following an office visit?**

Medicare pays both visits if a patient is seen in the office on one date and admitted to the hospital on the next date, even if fewer than 24 hours has elapsed between the visit and the admission.

3. **If we decide to admit from the office, should we bill the office visit and the lowest initial admission code?**

No, if admitting the patient after an office visit, the initial hospital code would include all work performed by the physician in all sites. The initial hospital care day would be the only code reported if the physician performed a face-to-face visit in the hospital setting as well as the office.

4. **Will Medicare pay for more than one initial hospital visit per hospital admission?**

In the inpatient hospital setting and nursing facility setting, any physician and/or qualified non-physician practitioner who perform an initial evaluation may bill an initial hospital care visit code (99221 – 99223) or nursing facility care visit code (99304 – 99306), where appropriate. Medicare will only pay for one initial hospital care day per patient, per admission, per specialty.

Reference

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.9.1G

5. **Am I permitted to bill an initial hospital visit (for a consultation) even though I have an established relationship with the patient?**

Yes. The concept of a new or established patient does not apply to inpatient hospital care days. Practitioners can use these codes for the first visit to an inpatient even if they have an established relationship with the patient.

6. **Will Medicare allow an initial hospital care visit and a discharge to be paid on the same day?**

When the patient is admitted to inpatient hospital care for less than eight hours on the same date, then initial hospital care (99221–99223) shall be reported by the provider. The hospital discharge day management service (99238 or 99239) shall not be reported for this scenario.

When a patient is admitted to inpatient initial hospital care and discharged on a different calendar date, the physician shall report an initial hospital care (99221–99223) and a hospital discharge day management service (99238 or 99239).

When a patient has been admitted to inpatient hospital care for a minimum of eight hours but less than 24 hours and discharged on the same calendar date, observation or inpatient hospital care services (including admission and discharge services), from code range 99234-99236, shall be reported.

7. **One of the cardiologists from our group saw a patient in the hospital this morning. The patient worsened and needed to be seen later in the day. Can the first cardiologist bill an initial and the other cardiologist bill a subsequent visit.**

No. Medicare does not pay two 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. Physicians (same group/same specialty) must bill and be paid as a single physician. Select a level of service representative of the combined visits and submit appropriate code.

8. **Where can I find guidelines for initial hospital visits?**

The guidelines for initial hospital visits can be found in the CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.9 .

Additional references

- 1995 E/M Guidelines
- 1997 E/M Guidelines
- CMS Evaluation and Management Services Guide

Subsequent

1. **Is it a requirement to document the past, family, and social history (PFSH) for subsequent in-hospital visits?**

For the categories of subsequent hospital care and subsequent nursing facility care, the current procedural terminology requires only an "interval" history. It is not necessary to record information about the PFSH. An "interval" history would include changes from the previous encounter to the present.

2. **Can two different providers bill a subsequent hospital visit on the same day?**

Subsequent hospital care codes are "per diem" services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice. Physicians of different specialties may each report a subsequent hospital visit on the same day.

Reference

CMS IOM Pub. 100-04 Claim Processing Manual, Chapter 12, section 30.6.9

Discharge day management

1. **Can any physician bill the hospital discharge day management service?**

Only the attending provider of record reports the discharge day management service.

2. **How do I bill discharge day management when I discharged my patient on day one, but dictated my notes on day 2? Which day do I use for submitting the claim?**

Bill the discharge day management with the actual discharge date. The medical records should clearly state the date of the actual discharge and dictated the following date.

Reference

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.9.2

3. **How are hospital discharge services reported?**

The CPT manual explains, hospital discharge day management codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status.

- 99238 – Hospital discharge day management; 30 minutes or less
- 99239 – Hospital discharge day management; more than 30 minutes

To report services for a patient who is admitted inpatient and discharged on the same date, use codes 99234-99236 for observation or inpatient hospital care including admission and discharge of the patient on the same date. To report concurrent care services provided by an individual other than the practitioner performing the discharge day management service, use subsequent hospital care codes (99231-99233) on the day of discharge.

Note: For observation care discharge, use 99217; for nursing facility care discharge, use 99315, 99316.

4. **What date is used when reporting a hospital discharge day management service?**

A hospital discharge day management service (99238 or 99239) is a face-to-face E/M service between the attending provider and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner (NPP), even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is payable per patient, per hospital stay.

Only the attending provider of record reports the discharge day management service.

Medicare pays for the paperwork of patient discharge day management through the pre-and post-service work of an E/M service.

5. **Will Medicare pay for multiple hospital discharges on the same calendar day for the same patient?**

No, only one discharge is permitted per patient admission.

To report concurrent care services provided by an individual other than the practitioner performing the discharge day management service, use subsequent hospital care codes (99231-99233) on the day of discharge.

6. **What if the attending provider of record is not available to discharge a patient but his partner from his same group is?**

It is also acceptable for physicians of the same specialty from the same group practice to discharge. Physicians of the same group with the same specialty are recognized as a single physician.

7. **Who is paid for the hospital discharge management and death pronouncement?**

Only the physician who personally performs pronouncement of death shall bill for the face-to-face hospital discharge day management service (99238 or 99239). The date of the pronouncement shall reflect the calendar date on the day the service was performed, even if paperwork is delayed to a subsequent date.

8. **How do you bill for a patient who expired?**

According to established legal principles, an individual is not deceased until there has been official pronouncement of death. Therefore, an individual expired at the time of pronounced of death by a legally authorized person who is usually a physician. Reasonable and necessary medical services rendered up to and including pronouncement of death by a physician are covered diagnostic or therapeutic services.

References

- CMS IOM Pub. 100-03, National Coverage Determinations, Chapter 1, Part 1, section 70.4
- CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.9.2

9. **Why are services for hospital discharge day management being reduced from 99239 to 99238?**

Services may be reduced when the medical records do not contain the time the physician spent with the patient. Hospital discharge day management codes 99238 (30 minutes or less) and 99239 (more than 30 minutes) are time based so it is imperative that medical documentation reflect total time spent by a physician during the discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, (even if the time spent by the physician on that date is not continuous), instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

10. **If my patient is admitted at 11 pm and discharge at 9 am the next morning, can I bill the admission and discharge codes 99234-99236?**

Admission and discharge codes (99234-99236) are only billable when admission and discharge occur on the same calendar day and includes more than 8 hours but less than 24 hours. Each calendar day is billable as long as a face-to-face visit is done on both.

11. **Does Medicare allow a hospital discharge management and nursing facility admission to be paid when rendered on same day?**

When a patient is discharged from a hospital and admitted to a nursing facility on same day, Medicare may pay the hospital discharge code (code 99238 or 99239) in addition to a nursing facility admission code when billed by the same physician with the same date of service.

12. **Rather than obtaining copies of pages from the hospital record, is it sufficient to send a statement that I spent more than 30 minutes in my discharge activities, as long as I give the specifics regarding patient name, health insurance claim number, and date of service?**

While this information is necessary when billing 99239, it is essential to send the visit note or discharge summary from that date of service, in order to substantiate the service billed.

Reference

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.9.2

Nursing facility

1. **Are 'incident to' services excluded in skilled nursing facilities (SNFs)?**

Where a physician establishes an office in a SNF/NF, the "incident to" services and requirements are confined to this part of the facility designated as his/her office. "Incident to" E/M visits, provided in a facility setting, are not payable under the physician fee schedule for Medicare Part B. Thus, visits performed outside the designated "office" area in the SNF/NF would be subject to the coverage and payment rules applicable to the SNF/NF setting and should not be reported using CPT codes for office or other outpatient visits or place of service code 11.

Reference

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.13E

2. **Can a qualified non-physician practitioner perform the initial visit in a skilled nursing facility and/or nursing facility?**

The initial visit in a SNF or nursing facility (NF) procedure codes 99304-99306, must be performed by a physician except as otherwise permitted (42 C.F.R. 483.40 (c) (4)). The initial visit is defined as the initial comprehensive assessment visit during which a physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the nursing facility resident.

Further, per the long-term care regulations at 42 CFR 483.40 (c)(4) and (e)(2), the physician may not delegate a task that the physician must personally perform. Therefore, the physician may not delegate the initial visit in a SNF (place of service 31). This also applies to the NF (place of service 32) with one exception.

A qualified non-physician practitioner such as a nurse practitioner, physician assistant, or a clinical nurse specialist, who is not employed by the facility, may perform the initial visit when the State law permits.

Reference

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.13

3. **If I provide a service, under arrangement to a SNF that is subject to SNF consolidated billing, what rate do we charge the SNF for the service?**

The SNF and provider/supplier agree to contractual terms prior to services provided. As part of this agreement, the SNF and the supplier (could be an ambulance) negotiate the terms and amount of payment. According to the CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 6, section 10.4.1, "Medicare does not prescribe the actual terms of the SNF's relationship with its suppliers (such as the specific amount or timing of payment by the SNF), which are to be arrived at through direct negotiation between the parties to the agreement."

4. **Our physician provided a chest X-ray (code 71010) to a patient who is a resident of a SNF. How do we bill the chest x-ray?**

If the patient is in a SNF covered Part A stay, the physician/practitioner bills the professional component of the chest x-ray to Part B with modifier -26. The technical component of diagnostic tests/services is subject to SNF consolidated billing and billable by only the SNF. In this instance, the physician/practitioner looks to the SNF for payment of the technical component.

To determine whether a service/procedure is/is not subject to SNF consolidated billing, please refer to the Part B MAC update files housed on the CMS SNF Consolidated Billing Part B MAC File Expansion web page.

5. **If a physician/practitioner sees a SNF resident in their office for an office visit, is the office visit billed by the physician/practitioner and if so, what place of service code is used?**

The professional services that the physician/practitioner performs personally are not subject to SNF consolidated billing. Therefore, if the patient was in the office, the physician/practitioner bills the office visit to Part B with place of service code 11 (office). However, services performed 'incident to' the physician/practitioner services are subject to SNF consolidated billing and, therefore, billed by the SNF. In this instance, the physician/practitioner looks to the SNF for payment.

To determine whether a service/procedure is/is not subject to SNF consolidated billing, please refer to the Part B MAC update files housed on the CMS SNF Consolidated Billing Part B MAC File Expansion web page.

6. **Must a physician/practitioner (or any other entity) have an agreement with the SNF for services that are subject to consolidated billing?**

It is a best practice for a SNF to enter an arrangement with any outside provider/supplier from which the SNF's residents receive "bundled" services (services subject to SNF consolidated billing). The absence of an agreement does not relieve the SNF of its overall responsibility to furnish directly or under arrangement for all services that are subject to the consolidated billing requirement.

For additional information, please visit the CMS Best Practices web page.

Office

1. **What is the difference between "new" and "established" patient and "new" and "established" problem? Does it mean the same for a non-physician practitioner (NPP)?**

The terms "new" or "established" problem on the E/M score sheet refer to whether or not the problem is new or established to the examiner, e.g., physician/ NPP, and whether or not that problem is stable/worsening or whether the physician plans to conduct additional workup on that problem or not.

In CPT, a "new" patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

An "established" patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

CMS interprets 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.

Currently, under the CMS enrollment process, NPPs cannot designate a sub-specialty. An NPP can only designate their primary licensure, e.g., nurse practitioner, physician assistant, certified nurse midwife, etc.

Reference

CMS IOM Pub. 100-4, Claims Processing Manual, Chapter 12, section 30.6

2. **We are seeing denials for our physician's new patient visits indicating the patient was seen by our group in the last three years. Why is this occurring? What can we do about it?**

In multispecialty groups, when an NPP sees the patient, this may cause your new patient visit to deny for a physician. If you can provide documentation that shows the NPP and physician are trained in different specialties, request a redetermination of the claim with the documentation.

A new patient is 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.

Currently, under the CMS enrollment process, NPPs cannot designate a sub-specialty. An NPP can only designate their primary licensure, e.g., nurse practitioner, physician assistant, certified nurse midwife, etc.

Reference

CMS IOM Pub. 100-4, Claims Processing Manual, Chapter 12, section 30.6.7A

3. **I've seen a patient in my current office within the last three years. I opened a new office in a nearby state. Will the first time I see that patient in my new office constitute a new patient visit?**

No, the new patient rules apply to the new location as your National Provider Identifier follows you wherever you go. A new patient is 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.

Reference

CMS IOM Pub. 100-4, Claims Processing Manual, Chapter 12, section 30.6.7A

4. **The March 2013 CPT assistant professional edition (page 8) states that providers may bill an office/outpatient E/M visit (99211-99215) for meeting with a patient's family to discuss the patient's care, without the patient present. Is this appropriate billing under the Medicare program?**

No, billing office/outpatient E/M services (99211-99215), in the absence of the patient, is not billable under the Medicare program. Medicare requires a face-to-face with the patient to occur.

References

CMS IOM Pub. 100-02, Benefit Policy Manual, Chapter 15 section 30(A)

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.1

5. **Can we bill a medically necessary visit on the same day as a preventive medicine service?**

When a physician furnishes a routine physical exam as well as a medically indicated or covered visit during the same encounter, the covered visit is viewed as being provided in lieu of a part of the routine physical. For additional billing information on preventive physical exams and other preventive services, please refer to the preventive services document located in the Claims Center of our website.

6. **Can E/M visits be billed on the same day as inpatient dialysis?**

Payment for E/M procedure codes 99231-99233 will be bundled into payment for inpatient dialysis procedures 90935-90947 for services rendered on or after January 1, 1995. No payment will be made for the E/M visits if billed the same day as inpatient dialysis.

Incident to

1. **Can 99211 be billed incident to?**

99211 is an established patient office or other outpatient visit that may not require the presence of a physician. To bill incident to, all the incident to rules must be met. To ensure the services meet those requirements, utilize our incident to tool (JL) (JH) on our website. This applies to E/M services prior to 2021 and after.

References

CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 12, section 30.6.4