Medicare Learning Network
MLN Matters
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: 4032 MLN Matters Number: MM4032

Related CR Release Date: October 28, 2005

Related CR Transmittal #: 731

Effective Date: January 1, 2004, for chemotherapy and non-chemotherapy drug infusion codes and January 1, 2005, for therapeutic and diagnostic injection codes.

Implementation Date: January 3, 2006

Payment for Office/Outpatient E/M Visits (Codes 99201-99215)

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Physicians billing Medicare carriers for drug administration and for evaluation and management (E/M) services

Provider Action Needed

Physicians should note that this article clarifies and corrects the definition of "new patient" and "physician in a group practice" for billing evaluation and management (E/M) services and updates the policy on billing E/M services with drug administration codes in the *Medicare Claims Processing Manual.* Previously, Change Request (CR) 3631 instructed carriers not to allow payment for Current Procedural Coding Terminology (CPT) code 99211 if billed with a drug administration service, such as chemotherapy or non-chemotherapy drug infusion code. In the Medicare Physician Fee Schedule Final Rule published on November 15, 2004, this policy was expanded to include therapeutic and diagnostic injection codes.

The Medicare Claims Processing Manual (Chapter 12, Section 30.6.7) is updated stating that Medicare will pay for medically necessary office/outpatient visits billed on the same day as a drug administration service with modifier -25 when the modifier indicates that a separately identifiable evaluation and management (E/M) service was performed that meets a higher complexity level of care than a service represented by CPT code 99211.

The same section of the manual defines "new patient" for the E/M visit code and reads as follows. (The *italicized/bold words* are new.)

> Interpret the phrase "new patient" to mean a patient who has not received any professional services, *i.e., evaluation and management (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 three 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.

Paragraph B of Chapter 12, Section 30.6.7, clarifies "physician in a group practice" for office/outpatient E/M Visits provided on the same day for unrelated problems as follows:

> *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).

Paragraph D of the same section describes drug administration services and E/M visits billed on the same day of service as follows:

> 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 non-chemotherapy drug infusion service (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 14, 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.*

Implementation

The implementation date for this instruction is January 3, 2006.

Additional Information

To see the official instruction issued to your carrier regarding this change, go to *http://www.cms.hhs.gov/transmittals/downloads/R731CP.pdf* on the CMS website.

If you have any questions, please contact your carrier at their toll-free number, which may be found at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

For more information regarding the revised Payment for Office/Outpatient E/M Visits (Codes 99201-99215) see the *Medicare Claims Processing Manual,* Chapter 12, Section 30.6.7, at *http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf* on the CMS website.