

Payment Policy: Hospital Visit Codes Billed with Labs

Reference Number: CC.PP.023

Product Types: ALL

Effective Date: 01/01/2013

Last Review Date: 11/01/2020

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

Hospitals may receive reimbursement for visit codes (evaluation and management services) in addition to a laboratory test, but only when the hospital provides a room for an evaluation and management service by a professional. If a significant and separately identifiable evaluation and management service is provided to the patient in addition to the lab work, modifier -25 should be appended.

Application

This policy applies to outpatient hospital claims.

Reimbursement

Claims Reimbursement Edit

The Health Plan's code editing software will flag all hospital claims billed with modifier -25 for prepayment clinical validation. Clinical validation occurs *prior to claims payment*. Once a claim has been clinically validated, it is either released for payment or denied for incorrect use of the modifier.

Rationale for Edit

A hospital should not bill a visit code, for use of an exam room, for a registered outpatient if the patient was not seen by a provider. Billing a visit code in addition to the laboratory visit is inappropriate when the only other service performed was the collection of a specimen. Like all other procedures, room charges are included in the reimbursement for the procedure.

Modifier -25 should only be used to indicate that a "significant, separately identifiable evaluation and management service (was provided) by the same physician or Other Qualified Health Care Professional on the same day of the procedure or other service."

Pre-payment Clinical Claims review

A significant, separately identifiable E/M service is substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. If medical records do not indicate that significant, separately identifiable services were performed, the primary procedure or other service will be paid and the secondary E/M billed with Modifier -25 will be denied.

To avoid incorrect denials, providers should assign all applicable diagnosis codes that support the E/M services reported.

PAYMENT POLICY HOSPITAL VISIT CODES W LABS

Documentation Requirements

Documentation from the physician or other qualified health care professional should indicate that an evaluation and management service was provided. The key components of an E/M service (history, examination and medical decision making) must be documented.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Modifier	Descriptor
-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

Definitions

Not Applicable

Related Policies

Not Applicable

Related Documents or Resources

Not Applicable

References

1. *Current Procedural Terminology (CPT®)*, 2020
2. *HCPCS Level II*, 2020
3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2020
4. *ICD-10-CM Official Draft Code Set*, 2020
5. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services.
6. *Centers for Medicare and Medicaid Services*, National Correct Coding Initiative (NCCI) publications.
7. *American Medical Association*, Current Procedural Terminology (CPT®) and associated

Revision History	
05/09/2017	Converted to new template and conducted review.
05/26/2017	Corrected Spelling Error in Title
06/20/2018	Conducted annual review
09/01/2019	Conducted review, updated coding information
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains

PAYMENT POLICY HOSPITAL VISIT CODES W LABS

the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

©2020 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.