



Evaluation & Management (E&M)

The *Physicians' Current Procedural Terminology – 4th Edition* (CPT-4) book includes codes for billing Evaluation and Management (E&M) procedures. It is important that providers use the current version of the CPT-4 and report E&M code definitions carefully.

General Information

The following paragraphs include general information about E&M procedures.

Levels of Care

Within each category and subcategory of E&M service, there are three to five levels of care available for billing purposes. These levels of care are not interchangeable among the different categories and subcategories of service. The components used to describe and define the various levels of care are listed in the “Evaluation and Management” section of the CPT-4 book.

Unlisted E&M Services

CPT-4 codes 99429 (unlisted preventive medicine service) and 99499 (unlisted evaluation and management service) require an approved *Treatment Authorization Request* (TAR) in order for these codes to be reimbursed.

Providers should include the following documentation when requesting the TAR:

- An adequate definition or description of the nature, extent and need for the procedure or service
- The time, effort and equipment necessary (if appropriate) to provide the service

Modifiers

Modifiers used to describe circumstances that modify a listed E&M code are listed with their descriptors in the *Modifiers: Approved List* and *Modifiers Used With Procedure Codes* sections of the appropriate Part 2 manual.

Psychotherapy Services

Refer to the *Psychiatry* section in the appropriate Part 2 manual for information about billing E&M services in conjunction with psychotherapy services.

New Patient Reimbursement

A new patient is one who has not received any professional services from the provider within the past three years. If a new patient visit has been paid, any subsequent claim for a new patient service by the same provider, for the same recipient received within three years will be paid at the level of the comparable established patient procedure.

RAD Reductions

The payment resulting from this change in the level of care will be made with a Remittance Advice Details (RAD) message defining the reduction as being in accordance with the service limit set for the procedure. These codes are listed in the *Remittance Advice Details (RAD) Codes and Messages: 001 – 9999* sections in the Part 1 manual. Providers who consider the service appropriate and the reduction inappropriate should submit a *Claims Inquiry Form (CIF)*.

Established Patient Reimbursement

An established patient is one who has received professional services from the provider within the past three years.

Providers On Call

If a provider is on call or covering for another provider, any service rendered must be classified as it would have been by the provider who is not available.

E&M Services Separately Reimbursable

The following CPT-4 codes for E&M services are separately reimbursable if billed by the same provider, for the same recipient and same date of service, and if the required documentation is included in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment included with the claim.

- New patient, office or other outpatient visit (99201 – 99205) and new or established patient, office or other outpatient consultation (99241 – 99245)

Claims for codes 99241 – 99245 must document the following:

- Another provider requested the patient consultation;
- Consultation was regarding a separate problem than that of the earlier initial patient visit; and
- Medical necessity.

- New or established patient, subsequent hospital care (99231 – 99233) and new or established patient, initial inpatient consultation (99251 – 99255)

Code combinations 99231 – 99233 and 99251 – 99255 may be reimbursed when:

- Two different physicians provide inpatient services to the same recipient on the same date with the same group provider number. Documentation must be submitted with the claim to medically justify two services on the same day.
- One physician provides inpatient services to a recipient twice on the same date of service. Documentation must be submitted with the claim to medically justify two services on the same day.

Frequency Restrictions

The frequency restriction for CPT-4 codes 99211 – 99214 may be exceeded with medical justification. Providers must submit the medical justification with the original claim when established E&M visits exceed six in 90 days. Providers must document that the patient's acute or chronic condition requires frequent visits in order to monitor their condition with the goal of decreasing hospitalizations.

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Dispensing of Hormonal
Contraceptives

Refer to the *Family Planning* section in the appropriate Part 2 manual for information regarding E&M services and dispensing of hormonal contraceptives.

**Prolonged
E&M Services**

Prolonged services include outpatient services (CPT-4 codes 99354 and 99355) and inpatient services (CPT-4 codes 99356 and 99357). Reimbursement for these codes requires a minimum of 30 minutes face-to-face contact or unit/floor time beyond the typical time of the visit to be reported. A prolonged service of less than 30 minutes is included in the original visit and should not be reported.

Outpatient Services
CPT-4 Code 99354

To report prolonged outpatient E&M services, CPT-4 codes 99354 (office or outpatient setting; first hour) must be billed in conjunction with one of the following E&M codes.

<u>CPT-4 Code</u>	<u>Description</u>
99201 – 99205 99212 – 99215	Office or other outpatient visit
99241 – 99245	Office or other outpatient consultation
99324 – 99328 99334 – 99337	Domiciliary, rest home, or custodial care visit
99341 – 99345 99347 – 99350	Home Visit
90809, 90815	Outpatient psychotherapy with E&M component

CPT-4 Code 99355

To report additional prolonged outpatient E&M services, CPT-4 code 99355 (each additional 30 minutes) must be billed in conjunction with code 99354.

Billing Calculations

CPT-4 codes 99354 and 99355 are subject to the least restrictive frequency limitation as the required companion code. To calculate the amount of time that is payable for prolonged outpatient services, take the total face-to-face time and subtract the time of the primary E&M service. The following table may be used to calculate billing for prolonged outpatient E&M services.

<u>Time of E&M visit code not included</u>	<u>First hour</u>	<u>Each additional 30 minutes</u>
Less than 30 minutes	Not reported	Not reported
30 – 74 minutes	99354	Not reported
75 – 104 minutes	99354	99355
105 – 134 minutes	99354	99355 (quantity of 2)
135 – 164 minutes	99354	99355 (quantity of 3)
165 – 194 minutes	99354	99355 (quantity of 4)

Inpatient Services
CPT-4 Code 99356

To report prolonged inpatient E&M services, CPT-4 codes 99356 (inpatient setting; first hour) must be billed in conjunction with one of the following E&M service codes:

<u>CPT-4 Code</u>	<u>Description</u>
99221 – 99223 99231 – 99233	Initial hospital care and subsequent hospital care
99251 – 99255	Inpatient consultation
99304 – 99310	Nursing facility services
90822, 90829	Inpatient psychotherapy with E&M component

CPT-4 Code 99357

To report prolonged inpatient E&M services, CPT-4 codes 99357 (each additional 30 minutes) must be billed in conjunction with code 99356.

Billing Calculations

CPT-4 codes 99356 and 99357 are subject to the least restrictive frequency limitation as the required companion code. To calculate the amount of time that is payable for prolonged inpatient services, take the total unit/floor time and subtract the time of the primary E&M service. The following table may be used to calculate billing for prolonged inpatient E&M services.

Time of E&M visit code <u>not included</u>	<u>First hour</u>	<u>Each additional 30 minutes</u>
Less than 30 minutes	Not reported	Not reported
30 – 74 minutes	99356	Not reported
75 – 104 minutes	99356	99357
105 – 134 minutes	99356	99357 (quantity of 2)
135 – 164 minutes	99356	99357 (quantity of 3)
165 – 194 minutes	99356	99357 (quantity of 4)

Emergency Department Services

Claims for emergency department E&M services must be accompanied by an appropriate diagnosis code reflecting the need for the level of E&M services rendered. Inappropriate upcoding is subject to audit.

No distinction is made between new and established patients in the emergency department. Providers must use CPT-4 codes 99281 – 99285 when billing for emergency department services, whether the patient is new or established.

If a recipient visits the emergency department more than once on the same date of service, the provider should use the recipient’s records from the first visit instead of completing a new evaluation. Claims for E&M services rendered more than once in the emergency department by the same provider, for the same recipient and date of service are reimbursable only if they contain medical justification or an indication from the provider that the recipient came to the emergency department more than once in the same day.

Note: Evaluation and Management (E&M) CPT-4 codes 99281 – 99285 are physician service codes and under most circumstances, only physicians may submit claims for these codes. The treating physician and the emergency department services may not submit separate claims using these codes for the same recipient and date of service.

E&M codes 99284 and 99285 are not reimbursable together or more than once to the same provider, for the same recipient and date of service. Instead, providers should use code 99283 to bill for second and subsequent recipient visits on the same date of service.

E&M: Place of Service/
Facility Type Codes

The CPT-4 codes listed below are restricted to the following facility type/Place of Service codes:

<u>CPT-4 Code</u>	<u>Description</u>	<u>Facility Type UB-04</u>	<u>Place of Service Code CMS-1500</u>
99201 – 99215	Office Services	13, 71, 72, 73, 74, 75, 76, 79, 83	11, 22, 24, 25, 53, 65, 71, 72
99221 – 99233, 99238, 99239	Hospital Services	11, 12	21, 25
<u>99221 – 99223,</u> <u>99231 – 99233,</u> <u>99238, 99239,</u> <u>99241 – 99245,</u> <u>99251 – 99255,</u>	Subacute Care**		
99241 – 99245	Office Consultation	13, 14, 24, 33, 34, 44, 54, 64, 71, 72, 73, 74, 75, 76, 79, 83, 89	11, 12, 22, 23, 24, 25, 53, 55, 62, 65, 71, 81, 99
99251 – 99255	Initial Inpatient Consultation	11, 12, 25, 26, 27, 65, 71, 73, 74, 75, 76, 86, <u>89</u>	21, 31, 32, 53, 54, 99
99281 – 99285	Emergency Department Services	14*	23
99291 – 99292	Critical Care Services	11, 12, 13, 14*	21, 22, 23, 41, 42
99341 – 99350	Home Services	14, 24, 33, 34, 44, 54, 64	12, 55, 99
99460, 99462	Newborn Care	11, 12	21
99477	Neonate Intensive E&M	13, 14, 24, 34, 44, 54 or 64	21

* Facility type “14” must be billed in conjunction with admit type “1”

** Specify the appropriate Place of Service and use modifier U2.

Refer to the *CMS-1500 Completion* or *UB-04 Completion – Outpatient Services* section of the appropriate Part 2 manual for facility type/Place of Service codes and descriptions. Refer to the end of these sections to see the correspondence between local and national codes.

Claims for services rendered in an inappropriate facility type/Place of Service will be denied with RAD code 062, “The facility type/Place of Service is not acceptable for this procedure.”

Routine or Standing Orders – Hospitals and Nursing Facilities Level B (NF-B)

Services billed to Medi-Cal that are the result of routine or standing orders for admission to a hospital or Nursing Facility Level B (NF-B) are not reimbursable when applied indiscriminately to all patients. All patient orders, including standing orders for particular types of cases, must be specific to the patient and must represent necessary medical care for the diagnosis or treatment of a particular condition. Claims for routine orders will be subject to audit for medical necessity and will be denied if not justified by the facts relating to the case or if in excess of current patient needs.

The use of routine or standing orders is discouraged by the American College of Surgeons, the California Medical Association, the California Association of Hospitals and Health Systems, the Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association.

Board and Care Facility Services and Home Visit Codes

California Code of Regulations, Title 22, Section 51145 defines “home” as any place of residence of a recipient other than a hospital, Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B) where the recipient is a registered inpatient.

Since board and care facilities can be considered “home” for Medi-Cal patients, home visit CPT-4 codes 99341 – 99350 may be used to bill Medi-Cal for visits to patients in these facilities. Procedure codes 99304 – 99316 or 99334 – 99336, used for visits to board and care facilities, are not acceptable and may lead to claim denial. For services rendered in a board and care facility, use the “home” facility type code “33” on the *UB-04* or Place of Service code “12” on the *CMS-1500* for proper reimbursement.

**Nursing Facilities:
Frequency of
Physician Visits**

Reimbursement for physician visits to patients in Nursing Facilities is limited to once a month in NF Level B (NF-B) facilities, and once every two months in NF Level A facilities (NF-A). Medi-Cal regulations mandate visits no less often than once every 30 days for the first 90 days following admission to an NF-B and no less often than once every 60 days for an NF-A patient. To allow flexibility in scheduling NF visits and also to meet medical requirements, Medi-Cal reimburses for visits once a month for NF-B patients and 55 – 60 days for NF-A patients.

**Billing Instructions:
Additional Visits**

In those unusual circumstances that require physician visits in excess of the frequencies above, providers must include justification for the additional visits in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment included with the claim.

Hospital Visits

Physicians submitting claims to Medi-Cal for hospital visits and consultations are reminded that each physician is limited to one initial hospital visit (CPT-4 codes 99221 – 99223) during the recipient's hospital stay.

**Cutback
Reimbursement Rates**

Reimbursement for initial inpatient consultation services billed in excess of one per month is cut back as follows:

<u>Billed Code</u>	<u>Cutback Code</u>
99251	99231
99252	99231
99253	99232
99254	99232
99255	99232

When any of the following procedure codes have been reimbursed within a previous period of three years to the same provider, for the same recipient, any new patient office visit or home visit codes billed by the provider will be reduced to the reimbursement rate of the corresponding, established visit procedure codes.

<u>CPT-4 Code Range</u>	<u>Description</u>
99211 – 99215	Established patient; office or other outpatient visit
99221 – 99223	New or established patient; initial hospital care
99231 – 99233	subsequent hospital care
99241 – 99245	office consultation
99251 – 99255	initial inpatient consultation
99347 – 99350	Established patient; home visit
99354 – 99357	Prolonged physician service with direct (face to face) patient contact

These restrictions do not apply to California Children’s Services (CCS) or the Genetically Handicapped Persons Program (GHPP).

Hospital Visit/Discharge Services Rendered on Same Date of Service

A hospital visit (CPT-4 codes 99221 – 99223 and 99231 – 99233) is not separately reimbursable when billed with a hospital discharge service (codes 99238 – 99239) for the same date of service, for the same provider. However, reimbursement will be allowed for both services when different rendering providers are billing using the same group provider number.

Outpatient Visits: Reimbursement Based on Recipient’s Age

Medi-Cal reimburses codes 99205 (new patient visit, level five) and 99215 (established patient visit, office or other outpatient visit, level five) at different levels based on the patient’s age. Therefore, payment reflected on the RAD will vary depending on the age of the patient.

Additional E&M Home Visits Require Justification

Only one E&M home visit (CPT-4 codes 99341 – 99350) is reimbursable when submitted by the same provider, for the same recipient and date of service. Additional home visits billed on the same day, and home visits billed on the same day in conjunction with office visit codes 99201 – 99215 and 99241 – 99245 and select surgical procedure codes, require medical justification that must be documented in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) or on an attachment to the claim.

Pre-Operative Exam Billing by Outpatient Surgery Clinics

Outpatient surgery clinics may not bill Medi-Cal for E&M of a new patient in addition to the surgical procedure performed because this service has already been provided by an attending physician who may bill for this service under his/her own National Provider Identifier (NPI). Outpatient surgery clinics' claims for initial office visit procedure codes (CPT-4 codes 99201 – 99205) will be denied.

Pre-Operative Exam Not Separately Reimbursable From Surgery

Under most circumstances, including ordinary referrals, the pre-operative examination by the operating surgeon or assistant surgeon in the emergency room, hospital or elsewhere on the day of surgery, or one day prior to the day of surgery, is considered a part of the surgical procedure and is not separately reimbursable by Medi-Cal.

Note: CPT-4 codes 99201 – 99215 rendered by the primary or assistant surgeon are not separately reimbursable unless medical justification is attached to the claim. He/she must document medical justification in the remarks section of the claim when a pre-operative visit is performed on the day before or day of surgery.

Billing Exceptions to Pre-Operative Policy

Exceptions to this policy may be made when the pre-operative visit is an initial emergency visit requiring extended evaluation or detention (for example, to prepare the patient or establish the need for the surgery).

Procedures (for example, bronchoscopy prior to thoracic surgery) that are not normally an integral part of the basic surgical procedure may be reimbursed separately.

Post-Operative Services Not Separately Reimbursable When Billed Within Surgery Follow-Up Period

Office visits, hospital visits, consultations and ophthalmological exams (CPT-4 codes 92002 – 92014, 99201 – 99215, 99221 – 99233, 99238, 99239 and 99241 – 99275) related to a surgery and billed during the follow-up period of the surgery, are not separately reimbursable if billed by the surgeon or assistant surgeon.

These claims will be denied with RAD code 074: "This service is included in the surgical fee." Surgical follow-up periods are given in the 1969 CRVS.

**Emergency Room Visits
and Critical Care Not
Separately Reimbursable**

Emergency room E&M CPT-4 codes 99281 – 99285 and critical care and E&M codes 99291 and 99292 are not separately reimbursable if billed by the same provider for the same recipient and date of service. Because emergency room services and critical care E&M require the same three key components (a patient history, examination of the patient and medical decision-making), submitting claims for both constitutes double billing.

If emergency room and critical care E&M services are both billed, Medi-Cal will reimburse only up to the allowed amount of the higher-priced service.

Initial Inpatient Consultations

Claims billed with CPT-4 code 99253 – 99255 (initial inpatient consultation visits) are reimbursable more than once every six months when billed by the same provider, for the same recipient, when medically necessary. Justification must be documented in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) or on an attachment included with the claim.

Note: This policy also applies to claims billed with a group provider number.

**Physician Office/
Outpatient Consultations**

A physician consultation billed with CPT-4 code 99243 – 99245 performed within six months of a previous consultation (CPT-4 codes 99241 – 99245) by the same group or rendering provider are reimbursed at the rate for CPT-4 code 99241.

Note: This policy also applies if the claims for the initial and subsequent consultations have the same group number but different rendering provider numbers.

**Physician Visits:
"State" Hospitals**

Physicians treating patients at State hospitals must use home visit CPT-4 codes 99341 – 99350 with the appropriate Place of Service "Other" code. Providers billing on the *UB-04* claim should use facility type code "14," "24," "34," "44," "54" or "64." Providers billing on the *CMS-1500* claim should use Place of Service code "55" or "99." Enter in the *Reserved for Local Use* field (Box 19) of the claim the reason for the visit when billing with Place of Service code "55." Facility type/Place of Service code "14," "24," "34," "44," "54," "64," "55" or "99" must be used for visits to State hospitals under the home visit procedure code to ensure proper reimbursement. Claims submitted with an inappropriate facility type/Place of Service code will be denied.

**Physician Standby/
Detention Time**

Standby physician services are billed under CPT-4 code 99360 for detention time. This procedure must be billed “By Report.”

**CPT-4 Code 99360:
Documentation
Requirements**

When billing for these services, providers must include the following documentation:

- * The procedure requiring the physician’s full-time attendance
- * The medical necessity for the physician’s immediate presence
- * A detailed report of the tasks performed
- * The duration of the actual time spent with the patient

Physician standby (detention) time during anesthesia administered by a nurse anesthetist for either podiatric or dental surgery will be reimbursed when a supervising anesthesiologist is not available. The standby physician must be immediately available and in close proximity to the operating room but not necessarily in the operating room.

The claim must contain a statement explaining that an anesthesiologist was not available to supervise the anesthesia, and that the standby physician was immediately available to the operating room. The statement must be signed by the attending or standby physician.

**Critical Care Codes
99291 and 99292**

Services rendered and billed with code 99360 must not include services provided during the time period when CPT-4 code 99291 or 99292 is billed.

**Pediatric Critical Care
Patient Transport Codes
99466 and 99467
99485 and 99486**

These codes are used to report the physical attendance and direct face-to-face care by a physician during the inter-facility transport of a critically ill or critically injured pediatric patient. Reimbursable time begins when the physician assumes primary responsibility for the pediatric patient at the referring hospital/facility and ends when the receiving hospital/facility accepts responsibility for the care of the patient. Providers should report only the time spent in direct face-to-face contact with the patient during the transport. Code 99466 covers the first 30 to 74 minutes of hands-on care during transport. Code 99467 covers the same service for each additional 30 minutes.

Services rendered and billed with code 99467 must only be billed in conjunction with code 99466. Reimbursement is restricted to recipients 24 months of age or less. Providers must document medical justification when billing code 99467 for a quantity greater than one.

CPT-4 codes 99485 and 99486 are used to report the control physician's non-face-to-face supervision of interfacility pediatric critical care transport. Code 99486 must be billed in conjunction with code 99485.

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| 99485 | supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 month of age or younger, includes two-ay communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report, first 30 minutes |
| 99486 | each additional 30 minutes |

**Preventive Medicine
Services for Children**

Office visits for preventive medical care for children must be billed using CPT-4 codes 99381 – 99384 and 99391 – 99394, as appropriate. When these codes are billed inappropriately, reimbursement of claims is delayed for medical review and subsequently reduced to more appropriate rates.

Note: Medi-Cal providers who also are enrolled as Child Health and Disability Prevention (CHDP) Program providers cannot bill Medi-Cal for these codes.

Newborn Care

Normal newborn care should be billed with CPT-4 code 99460 for the first day of care when the service is provided in a hospital or a birthing care center. CPT-4 code 99462 should be billed on a separate claim line if there is subsequent hospital care. When a newborn is admitted and discharged on the same date, neither CPT-4 code 99238 nor code 99239 can be billed with code 99460 for the same date of service, any provider.

The following policies apply to billing procedures for newborn care:

- CPT-4 code 99460 (history and examination of the normal newborn infant) may be reimbursed only once to any provider for the same recipient. Code 99460 will not be reimbursed if it is billed subsequent to any other initial hospital inpatient services (99221 – 99223).
- CPT-4 code 99462 (subsequent hospital care, for the evaluation and management of a normal newborn, per day) may be reimbursed for up to two days of hospital care for the same recipient, any provider when the diagnosis code indicates a vaginal delivery. CPT-4 code 99462 may be reimbursed for up to four days of hospital care for the same recipient, any provider when the diagnosis code indicates a cesarean section delivery.
- Reimbursement for CPT-4 codes 99222 and 99223 is reduced to the same rate as 99460 if the diagnosis code indicates a healthy newborn (V30.00 – V39.11).
- Reimbursement for CPT-4 codes 99231 – 99233 is reduced to the rate of 99462 if the diagnosis indicates a healthy newborn (V30.00 – V39.11). All other hospital visit codes billed by the same provider, for the same recipient and date of service will be denied.

- CPT-4 codes 96110 and 96111 (administration and interpretation of developmental tests, limited or extended, respectively) and 99238 and 99239 (hospital discharge day management) are not reimbursable if billed within one month of code 99460 or 99462 (normal newborn care services) by the same provider for the same recipient.

Neonatal and Pediatric Intensive Care Guidelines

The following information describes the billing guidelines for neonatal and pediatric intensive care services.

Neonate, Intensive E&M

CPT-4 code 99477 (initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services) has the following policy:

- Another initial hospital visit(s) may not be reimbursed on the same day as code 99477.
- If billed with an ICD-9-CM diagnosis code of V30.00 – V39.11, reimbursement will be cut back to the rate of CPT-4 code 99460.

Neonatal, Hypothermia

Hypothermia for critically ill neonates is reimbursed with CPT-4 codes 99481 (total body systemic hypothermia in a critically ill neonate per day) and 99482 (selective head hypothermia in a critically ill neonate per day) when initiated within the first six hours of birth and discontinued after 72 hours.

Reimbursement is limited to three times in a recipient's lifetime for any provider.

Intensive Care in a CCS Approved NICU or PICU

Neonatal and Pediatric Intensive Care Unit (NICU/PICU) global HCPCS codes (Z0100 – Z0108) are reimbursed only for physician services provided in a facility approved by California Children's Services (CCS) as a regional, community or intermediate NICU or as a PICU.

Codes Z0100 – Z0108 are used to bill for 24 hours of care and only one code is reimbursable for the same recipient and date of service. If the recipient dies, or is transferred or discharged before midnight, a full day of care may be billed by the physician for that date.

From-Through” Billing	Physicians may bill HCPCS codes Z0102 – Z0108 using the “from-through” method.
Other Services Covered	<p>Each intensive care code covers <u>all</u> services rendered by a physician including umbilical catheterization, venipunctures, intubations, blood cultures, blood gas interpretations and delivery/ birthing room resuscitation. Only exchange transfusions (36450), chest tube insertions (32002) bronchoscopy services (31622 – 31651), and resuscitation (99465) are reimbursed if billed separately. Exchange transfusions (36450) are reimbursable for newborns up to one month old.</p> <p>Physician standby service requiring prolonged physician attendance, each 30 minutes (99360), is reimbursable only when billed in conjunction with HCPCS code Z0100. A physician billing codes Z0100 – Z0108 will not be reimbursed for any other physician service for the same recipient and date of service except as noted above. No other physician is reimbursed for NICU/PICU services for the same recipient and date of service. Other physicians may be reimbursed for essential services that are not included in the NICU/PICU codes. Physicians who bill services under a group provider number must enter their rendering provider number on the claim in the appropriate area.</p> <p>Note: The neonatal intensive care form used when billing NICU services is not required.</p>
Critical Care and Initial Neonatal and Pediatric Intensive Care Codes	<p>Providers may bill critical care codes (99291 or 99292) for services rendered before the child is admitted to the NICU/PICU when the global NICU/PICU code Z0100 is not billed by the <u>same</u> provider, for the same recipient and date of service. Providers billing code 99291 or 99292 may be reimbursed for services rendered to infants and children <u>prior</u> to the transfer to a NICU or PICU even if code Z0100 is billed by <u>another</u> provider for the same date of service. Enter in the <i>Remarks</i> field (Box 80)/<i>Reserved for Local Use</i> field (Box 19) of the claim that the service was rendered prior to transferring the recipient to a NICU or PICU.</p> <p>Note: Claims billed with codes Z0102 – Z0108 (neonatal and pediatric intensive care) or Z3012 (extracorporeal membrane oxygenation) will not be reimbursed if critical care code 99291 or 99292 has been previously paid to <u>any</u> provider on the same date of service. Also, claims billed with critical care code 99291 or 99292 will not be reimbursed if codes Z0102 – Z0108 or Z3012 have been previously paid to <u>any</u> provider for the same date of service.</p>

Initial Neonatal and Pediatric Intensive Care (HCPCS Code Z0100)

Providers should use HCPCS code Z0100 to bill for initial neonatal or pediatric intensive care (first or partial 24 hours). Code Z0100 may be billed only once using an individual claim line, a quantity of one, and the date of admission to the NICU/PICU as the date of service.

Note: Code Z0100 may be billed when the medical conditions of the child require repeated readmission to the NICU or PICU.

Subsequent Neonatal and Pediatric Intensive Care

Subsequent days of physician NICU/PICU care are billed using the following codes for each date of service, depending on the level of care (as listed below) provided to the patient at 2400 hours (midnight) on the date of service.

Category I (HCPCS Code Z0102)

Category I level of care: Children receiving ventilatory support (including continuous positive airway pressure [CPAP]), invasive monitoring, hyperalimentation, and/or intravenous pharmacological support of the circulatory system.

Category II (HCPCS Code Z0104)

Category II level of care: Children receiving intensive therapy and intravenous lines for medications or fluids, supplemental oxygen and/or feedings via nasogastric, orogastric, nasojejunal or gastrostomy tubes.

Category III (HCPCS Code Z0106)

Category III level of care: Children who are unstable, requiring frequent monitoring and assessment by trained personnel.

Category IV (HCPCS Code Z0108)

Category IV level of care: Children who are stable, receiving routine medical and nursing care prior to discharge from the NICU/PICU. Code Z0108 may be used by physicians to bill the last day of care in the NICU/PICU. The date of service is the date of discharge from the NICU/PICU.

Extracorporeal Membrane
Oxygenation (ECMO) –
HCPCS Code Z0312

Neonatologists are reimbursed for ECMO services only when provided to newborns in CCS-approved ECMO centers. HCPCS code Z0312 covers all examinations and procedures performed during a 24-hour period of ECMO treatment of an infant by a neonatologist. No other physician service, including HCPCS codes Z0100 – Z0108, will be reimbursed in conjunction with code Z0312 by any provider, for the same recipient and date of service.

Billing for Services to
Multiple Newborns

When billing for care of multiple newborns, complete Boxes 2, 3, 4 and 6 on the *CMS-1500* claim or Boxes 12, 14, 15, 58 and 59 on the *UB-04* claim. Refer to the appropriate claim form completion section in this manual for specific instructions on completing these boxes.

Note: When billing for a birth occurring to the same mother within six months of a previous birth, identify the second birth with the alpha or numeric indicator “B” or “2” (for example, Jones, Baby Girl, B).

NICU and PICU Care in
Non-CCS Approved Facilities

Physician services provided in a NICU/PICU facility not certified by California Children’s Services (CCS), or not having CCS-equivalent resources, services and equipment, must be billed using the appropriate critical care visit codes (code 99291 or 99292), hospital admission codes (codes 99221 – 99223, 99460) or hospital visit codes (99231 – 99233, 99462).

Critical Care:
Services Not
Separately Reimbursable

The following services are included in CPT-4 codes 99291 (critical care, first hour) and 99292 (critical care, each additional 30 minutes) and are not separately reimbursable when billed by the same provider, for the same recipient and date of service.

<u>CPT-4 Code</u>	<u>Description</u>
36000	Introduction of needle or intracatheter, vein
36410	Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36600	Arterial puncture, withdrawal of blood for diagnosis
71010 *	Radiologic examination, chest; single view
71020 *	two views
91105	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)
92953	Temporary transcutaneous pacing
93561 *	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement
93562 *	subsequent measurement of cardiac output
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day
94003	subsequent days
94660	Continuous positive airway pressure ventilation (CPAP), initiation and management
94662	Continuous negative pressure ventilation (CNP), initiation and management
99090	Analysis of clinical data stored in computers (for example, ECGs, blood pressures, hematologic data)

* Modifier 26 (professional component) is not reimbursable for these procedures.

Services Separately Reimbursable

Providers may be reimbursed separately only for the technical components of the following services. The professional components are included in codes 99291 and 99292 and are not separately reimbursable when billed by the same provider, for the same recipient and date of service.

<u>CPT-4 Code</u>	<u>Description</u>
71010	Radiologic examination, chest; single view
71020	two views
93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement
93562	subsequent measurement of cardiac output

Pulse Oximetry

CPT-4 code 94760 (non-invasive ear or pulse oximetry saturation; single determination) is reimbursable only to physicians when no other services are billed for the same recipient, by the same provider on the same date of service.

Cardiopulmonary Resuscitation

CPT-4 code 92950 (cardiopulmonary resuscitation [e.g., in cardiac arrest]) is reimbursable with codes 99291 and 99292.

Physician Standby Service (CPT-4 Code 99360)

Services rendered and billed with code 99360 must not include services provided during the time period when CPT-4 code 99291 or 99292 is billed.

Other procedures not directly related to critical care management, such as setting fractures or suturing lacerations, are not included when billing for critical care. These non-critical care procedures must be billed with the appropriate CPT-4 or HCPCS Level III codes.

**Teaching Physician
Billing Requirements for
Evaluation and Management
Services**

The Medi-Cal program will pay for direct patient care services in a teaching setting when directly provided by teaching physicians (*California Code of Regulations* [CCR], Title 22, Section 51503) The entry(ies) into the medical record by the teaching and resident physician(s) constitute the documentation for the services and together must support the medical necessity of the services.

Definitions:

- Resident physician:
A person who participates in an approved graduate medical education (GME) program, including programs in osteopathy, dentistry and podiatry. This includes interns, residents and fellows in the GME program but does not include students.
- Teaching physician:
A physician (other than another resident physician) who involves resident physicians in the care of his/her patients
- Approved graduate medical education program:
A residency program approved by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Council on Postdoctoral Training of the American Osteopathic Association, by the Commission on Dental Education of the American Dental Association, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

Evaluation and Management (E&M) services (CPT-4 codes 99201-99499) performed by teaching physicians must follow specific guidelines in order to allow payment for services provided. When physician services are provided by the resident and teaching physician, both of them must document their services in the patient's medical record. When the service has been performed in part by a resident physician, the claim must include the GC modifier (This service has been performed in part by a resident physician under the direction of a teaching physician) for each service. If the service was provided solely by the teaching physician, the claim should not be billed with the GC modifier.

On medical review, the combined entries into the medical record by the teaching physician and the resident physician constitute the documentation for the service and together must support the medical necessity of the service.

Payment may be made for any of the following three scenarios:

- The teaching physician personally performs all the required elements of an E&M service without a resident physician. The teaching physician must document as he/she would document in a non-teaching setting and the documentation must support the level of the service billed. This is the only scenario in which the GC modifier is not required.
- The teaching physician personally performs all the required elements of an E&M service and a resident physician has also performed and documented the E&M service. The teaching physician must document that he/she performed the E&M service and that he/she was directly involved in the management of the patient. The teaching physician may or may not reference the resident physician's documentation. The composite of the teaching physician's and resident physician's documentation together must support the level of the service billed by the teaching physician.
- The resident physician performs all the required elements of an E&M service in the presence of, or jointly with, the teaching physician and documents the service. In this scenario, the teaching physician must document that he/she was present during the performance of the service and that he/she was directly involved in the management of the patient. If the teaching physician does not perform all of the required elements of the E&M service, his/her documentation must reference the resident physician's documentation. The composite of the teaching physician's and resident physician's documentation together must support the level of the service billed by the teaching physician.

**Health and Behavior
Assessment/Intervention**

The following health and behavior assessment/intervention CPT-4 codes are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems:

<u>CPT-4 Code</u>	<u>Description</u>	<u>Frequency Limits</u>
<u>96150</u>	<u>Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment</u>	<u>2 per year any provider; 1 per day</u>
<u>96151</u>	<u>re-assessment</u>	<u>2 per year any provider; 1 per day</u>
<u>96152</u>	<u>Health and behavior intervention, each 15 minutes, face-to-face; individual</u>	<u>6 per year any provider; 2 per day</u>
<u>96153</u>	<u>group (2 or more patients)</u>	<u>6 per year any provider; 2 per day</u>
<u>96154</u>	<u>family (with the patient present)</u>	<u>6 per year any provider; 2 per day</u>

These CPT-4 code services do not represent preventive medicine counseling and risk factor reduction interventions.