Payment Policy: Professional Services (Visit Codes) Billed With Labs

Reference Number: CC.PP.019
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 12/01/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Providers may receive reimbursement for evaluation and management (E/M) services in addition to a laboratory test, but only when the provider performs a distinct and separately identifiable service in addition to the test. If a significant and separately identifiable E/M service is provided in addition to the lab work, modifier -25 should be appended. Modifier -25 should only be used to indicate that a "significant, separately identifiable evaluation and management service *(was provided)* by the same physician on the same day of the procedure or other service."

Application
This policy applies to Professional Claims.

Claims Reimbursement Edit
Code editing software flags all provider 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.

A significant, separately identifiable E/M service is substantiated by documentation that satisfies the criteria for the E/M service to be reported. If medical records do not indicate that significant, separately identifiable services were performed, the primary service is reimbursed, and the secondary E/M billed with modifier -25 is denied. To avoid incorrect denials, providers should assign all applicable diagnosis codes that indicate the need for additional E/M services.

Rationale for Edit
Providers should not bill E/M codes unless a separately identifiable E/M service is provided. Billing an E/M code when the only service is obtaining laboratory specimens is inappropriate.

Documentation Requirements
The following guidelines are used to determine whether modifier -25 was used appropriately. If any one of the following conditions is met, reimbursement for the E/M service is recommended.

- The E/M service is the first time the provider has seen the patient or evaluated a major condition
- Claim diagnoses indicate a separate condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures performed on or around the date of service

- A provider bills supplies/equipment, on or around the same date, that are unrelated to the procedure performed but would require an E/M service to determine the patient's need

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 2022, 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.

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

References

1. *Current Procedural Terminology (CPT®), 2022*
2. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services*
3. *CMS National Correct Coding Initiative (NCCI) publications*

Revision History	
03/07/2017	Converted to new template and conducted annual review.
03/10/2018	Reviewed and revised policy.
03/10/2019	Conducted Review, Verified Codes, Added 99288, updated policy
11/01/2019	Annual Review complete
11/01/2020	Annual Review complete
11/30/2021	Annual review complete; no major updates required
12/01/2022	Annual Review complete; no major updates required

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 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.