compliance

Is My E/M Visit Separately Billable?

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Due to the nature of their disease, patients with cancer may have many touch points with providers and staff, including building relationships and sharing personal stories, triumphs, and struggles. As such, it can be confusing for providers to know when time spent with a patient is an informal interaction (i.e., a component of their relationship) or when it is considered a billable service—especially when the physician is spending time with their patient.

There are also instances when a provider will see a patient and perform a minor procedure or other primary therapeutic service in addition to an evaluation and management (E/M) visit. Again, the question comes up: are these additional services separately billable?

Complicating this issue are the 2021 coding changes that shifted E/M visit coding to medical decision making and time-based requirements, raising additional questions as to which services are included in an E/M visit and which are separate and, therefore, separately billable. To begin the process of determining if a visit is separately billable, ask yourself these two questions:

1. Has there been a change in the patient since they were last seen by the provider, necessitating a visit with the patient today?
2. Is this a routine check-in to ensure that the patient can safely proceed with their therapy today?

Not Separately Billable

If a physician is checking in with the patient as part of a routine interval between drug administrations and there are no new symptoms or side effects, the visit *is not* separately billable. There is no medical necessity to support billing for an E/M visit. Rather, this check-in is considered a "courtesy."

Similarly, if the visit is a routine check-in, maybe it has been a week or two since the initial visit, and the plan of care to perform the setup simulation for radiation therapy is unchanged, then the E/M visit *is not* separately billable. Physicians must participate in these simulations, so any check-ins to see how patients are doing are a "courtesy" and not separately billable.

When a physician management service, Current Procedural Terminology (CPT®) codes **77427** to **77435**, is billed during the course of radiation therapy, the follow-up visit is considered part of the patient's ongoing management and therefore *is not* billable. The Medicare Claims Processing Manual, chapter 13, states that there are several services bundled into the physician management service.[1] The final bullet in the lengthy list of items includes: "Follow-up examination and care for 90 days after last treatment (whatever code billed)."

There is one exception to this rule. For certain brachytherapy treatments, when no physician management service is billed or if the patient presents for a new problem that was not previously known or symptomatic, the visit is considered "separately billable" and the provider can bill for an E/M visit.

Separately Billable

But what if there has been a change in the patient or there is no pre- or post-surgical period attached to the E/M visit? In these scenarios, providers may have an opportunity to bill for the E/M visit, in addition to any of the other services delivered on that same day. In the below scenarios, providers can bill a separate E/M visit, but they must also review new or recent diagnostic findings and/or results with the patient:

- The patient presents with a new problem or complaint. Examples include bone pain, dizziness, cognitive changes, deep vein thrombosis, or plural effusion symptoms.
- The patient presents with a side effect to their drug therapy, requiring assessment, intervention, or a new prescription. Examples include nausea, pain, fever, diarrhea, or mouth sores.
- There is a change in the drug therapy treatment plan that requires a discussion with the patient. Examples include need for new drug regimen, palliative care, or hospice.
- The patient has an adverse drug reaction, requiring assessment and/or intervention by the provider.

Documentation should clearly identify medical necessity to support the E/M visit and what about the patient has changed. To support billing for an E/M visit, the provider should select the CPT code that best represents the events and services that took place. Though the problem may be new, these patients are considered established to the physician or group, so the E/M visit is billed as an established patient visit.

Severe Drug Reactions

If a patient experiences a severe drug reaction, there is the potential for the physician to bill for their intervention and management of the patient on the same date the chemotherapy is administered. When drug administration codes were updated in 2005 and 2006, there was debate on how to bill these situations. At the time, a CPT Workgroup recommended that new codes be created to represent the physician intervention, but the CPT Editorial Panel did not agree. Instead, the panel said that physicians should bill using existing codes. The Centers for Medicare & Medicaid Services (CMS) indicated that the agency was aligning its guidance with the American Medical Association, publishing in the 2005 Medicare Physician Fee Schedule final rule that "physicians can bill existing codes that reflect the time, resources, and complexity of

services they and their staff provide for management of significant adverse drug reactions. Note that this is in addition to the billing normally allowed for the physician's care of a cancer patient."[2]

CMS outlined the existing codes that would be most appropriate and would depend on the specifics of the scenario. For example, a physician could bill for an E/M visit if the patient has a reaction during the chemotherapy administration and the physician must intervene. In this scenario, an E/M visit could be billed in addition to the chemotherapy administration services. If a patient visit was supported prior to the administration of the chemotherapy, a physician could bill a higher-level visit code for the complexity and time spent to manage the drug reaction. It may also be possible for providers to bill a prolonged service code. For example, if the total time is used when billing and that time exceeds the threshold for prolonged outpatient services, providers could bill for the add-on code in addition to the E/M code (CPT 99417 or HCPCS G2212). Lastly, if the patient had a visit prior to the chemotherapy administration and experiences life-threatening adverse reactions to the drugs, critical care services may be supported and billable if specific criteria are met (CPT 99291 or 99292).

Note: if the chemotherapy administration is started and then stopped due to a severe drug reaction, payers may allow providers to bill the full amount of the drug. The claim should be reported using the appropriate *International Classification of Diseases*, Tenth Revision, Clinical Modification codes to identify what took place:

- **Z53.09**: Procedure and treatment not carried out because of contraindication *AND*
- **T45.1X5A**: Adverse effect antineoplastic drug, active treatment (the secondary or tertiary code).

If a drug reaction is due to a medication error on the part of a physician or staff and requires administration of a "rescue" protocol, the additional drugs and administration services *are not* separately billable. In this scenario, the drug reaction was the result of a provider error and, therefore, the responsibility of the facility. It cannot be billed to the payer and patient.

When Additional Services are Performed at Time of Visit

Beyond the examples presented above, there may be instances when another service, such as a minor surgical procedure, is performed during the E/M visit, and this service may be separately billable. An example of this scenario would be a radiation oncologist who performs a nasopharyngoscopy or flexible fiberoptic laryngoscopy during the same encounter as the E/M visit. Often, when a radiation oncologist is seeing a patient with head and neck cancer, they will also perform a scope during the encounter. When the physician administers an anesthetic and inserts a scope through a nasal or oral approach to examine the larynx, this service is separately billed as:

- **31575**: Laryngoscopy, flexible fiberoptic; diagnostic.

If the physician administers an anesthetic and inserts an endoscope through the nose and into the pharynx to determine whether there are any fixed blockages, this service is billed as:

- **92511**: Nasopharyngoscopy with endoscope (separate procedure).

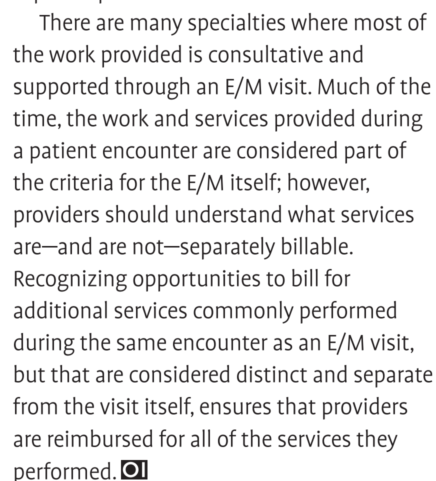
Regardless of which approach is used, providers should be specific in the documentation of the service performed. First, the anatomy viewed must be clearly stated in the procedure note. This will determine the type of service performed and the correct code to bill. Next, document the scope itself (ideally in a separate note) to fully support the additional and separately billable service. If the physician does not document separately, at minimum the service:

- Must be documented in a section of the visit note that is *not related* to the exam portion of the E/M visit.
- Must specifically call out the work that was done.

Use of Modifier 25 with E/M Visits

When an E/M visit is supported and there are other services also billed by the same physician, providers will typically encounter an edit. This may not happen on every service combination, but in oncology it is quite common. If the E/M visit is "above and beyond" the work of the other procedure or service performed, it is possible to add **modifier 25** (Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service) to the E/M visit code.

The use of modifiers when there is an edit does not guarantee payment. Additionally, because payers consider **modifier 25** to be overutilized, they look at it closely and require providers to document that the E/M visit was medically necessary and in addition to the procedure that was performed. As discussed previously, if the physician is simply checking in with the patient before their drug administration to assess how they are, explain the procedure, and obtain consent, payers *do not* consider this to be a separate patient encounter.



There are many specialties where most of the work provided is consultative and supported through an E/M visit. Much of the time, the work and services provided during a patient encounter are considered part of the criteria for the E/M itself; however, providers should understand what services are—and are not—separately billable. Recognizing opportunities to bill for additional services commonly performed during the same encounter as an E/M visit, but that are considered distinct and separate from the visit itself, ensures that providers are reimbursed for all of the services they performed. OI

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