2022 Policy Memo 2

Office/Outpatient Visit

BlueCross BlueShield Kansas

bcbsks.com

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For additional information on medical emergency or accident related visits, see Policy Memo No. 3, Outpatient Treatment of Accidental Injuries and Medical Emergencies. Home services may be billed as defined in the American Medical Association Current Procedural Terminology (CPT).

I. Definitions

Patient Status

A. New Patient: A patient who is new to the practice/physician or a patient who has not been seen for three or more years.

B. Established Patient: A patient who has been previously treated by the practice/physician and for whom records have been established within the past three years.

NOTE – Within a group practice, a consulting physician of a different specialty can bill a new or established patient office visit when the new or established patient definition above for the consulting physician has been met. This does not apply to covering arrangements.

Evaluation and Management Levels of Service

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) follows CPT guidelines for Evaluation and Management service levels.

II. Content of Service (See also Policy Memo No. 1)

Usual fees for the professional services for new and established patients are considered to include the following:

- Examination of patient.
- History of illness and/or review of patient records.
- Evaluation of tests or studies (i.e., radiology or pathology).
- Hearing and/or vision screenings.
- Any entries into the patient's record.
- Evaluation of reports of tests or studies earlier referred to another physician for an opinion and subsequently returned for use in the office visit being conducted.
- Advice or information provided during or in association with the visit.
- Case management.
- The prescription of any medicinals, home supplies or equipment during or as a result of the visit.
- The application or the re-application of any standard dressing during a visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
- Examination and/or treatment room.
- Items of office overhead such as malpractice insurance, telephones, computer equipment, software, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- Telephone calls and web-based correspondence are content of service when billed with another service on the same day. Telephone calls may be covered if it meets the telemedicine/telehealth definition and is billed with place of service 02 and the GT modifier.

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents.

NOTE – All-inclusive procedure codes must be used when appropriate.

A handling fee may be allowed under certain conditions. See Policy Memo No. 7, Radiology and Pathology.

III. Service Qualifying for a Separate Professional Fee in Addition to an Office/Outpatient Visit

- Charges for injectables may be listed separately from office visit fees and will be considered for payment separately. A separate administration fee will be allowed if no office visit is billed for therapeutic injections. Office visit services provided on the same day as an immunization or vaccine, may be billed in addition to the vaccine as long as medical need is justified.
- Laboratory examinations and/or diagnostic x-rays.
- Administration of chemotherapy when a separate and identifiable E&M is justified.
- In the case of a combination of office/home visits with physical therapy (modalities and/or procedures), services may be billed separately. The medical necessity of any physical therapy modality and/or procedure in excess of four on the same day must be supported with office records. See CPT for specific reporting of codes.

IV. Qualifications for Individual Consideration of Unusual Office/Outpatient Visit Charges

As with any unusual professional service, atypical office/outpatient visit fees are eligible for individual consideration when supportive medical records accompany the claim.

V. Outpatient Consultations

Consultations are services rendered to give advice or an opinion to a requesting physician about a patient's condition and/or management. Medical records must contain documentation of the actual request, the evaluation, and include a copy of the report that is sent to the physician who requested the consultation. Consultations by the same specialty or within the same group are subject to the medical review process. To use the consultation codes, three guidelines apply:

- The request for the consultation must be documented in the patient's medical record.
- The service must be for advice or opinion. While diagnostic work-up or therapy may be ordered and initiated by the consultant, this information must be documented in the record and included in the report to the referring physician.
- A report of the findings and advice must be sent to the referring physician.

When a consultant assumes responsibility for patient care (begins treating the patient, schedules follow-up care, etc.) the additional services are coded as office visits using the appropriate level of Evaluation and Management service for an established patient.

VI. Telemedicine

Telemedicine, including telehealth, is a covered service as per Kansas Telemedicine Act.

Telemedicine, including telehealth, means the delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site. Telemedicine shall be provided by means of real-time, two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

Telemedicine does not include communication between:

A. Health care providers that consist solely of a telephone voice-only conversation, email/eVisits, text, or facsimile transmission; or
B. A physician and a patient that consists solely of an email/eVisit, text, or facsimile transmission.

Physical therapy, speech therapy, occupational therapy, and audiology services are not covered as telehealth services.

"Health care provider" means a physician, licensed physician assistant, licensed advanced practice registered nurse, or person licensed, registered, certified, or otherwise authorized to practice by the behavioral sciences regulatory board (BSRB).

"Licensed mental health care professional" means an individual licensed by the BSRB who is acting within the scope of the individual's professional licensure act and held to the standards of professional conduct as set forth by the BSRB.

"Physician" means a person licensed to practice medicine and surgery by the state board of healing arts.

"Distant site" means a site at which a health care provider is located while providing health care services by means of telemedicine.

"Originating site" means a site at which a patient is located at the time health care services are provided by means of telemedicine.

The rendering provider, located at the distant site, cannot bill for both the telemedicine service and the originating site facility fee. The telemedicine originating site facility fee is appropriate to bill when there is an eligible provider coordinating care at the originating site.

Benefit coverage for health care services that are medically necessary – subject to the terms and conditions of the covered individual's health benefits plan – provided through telemedicine, rather than in-person contact or based upon the lack of a commercial office for the practice of medicine, will be the same when such services are delivered by a health care provider.

Note: Telehealth services should be billed with place of service 02 and with a GT modifier. Telehealth should not be billed when services are inappropriate as telehealth, e.g. laboratory services, vaccine administration, injections, radiology services, etc.

VII. Additional Policy Clarification

A. Office/outpatient visits provided on the same day as a hospital admission are considered content of the admission. (See In-Hospital Medical [Non-Surgical] Care Policy Memo No. 5.)
B. BCBSKS allows only one Evaluation and Management service per day per member by the same provider.
C. Contracting providers agree to assume the responsibility for filing covered office calls when there is payment for a portion of the service.
D. Observation care (23-hour observation) is allowed for unscheduled medical care. It is not intended for pre and postoperative care of the surgical patient. Only one observation service is allowed unless the 23-hour observation extends into the next calendar day. In this case, a

discharge observation would also be allowed. An observation care service is content of service of a hospital admission.

E. For new surgical patient visits, see Policy Memo No. 9, Section I., Paragraph C-2.

F. If a physician service is routinely provided to hospice patients, it is not separately billable.