Evaluation and Management Professional Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render professional services in an outpatient or office setting to members of the CarePartners of Connecticut plans selected above.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary evaluation and management (E&M) services, in accordance with the member's benefits.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Any evaluation and management (E&M) services related to an inpatient admission will be denied if an inpatient notification has not been obtained by the admitting facility.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of labs not participating in the member's applicable network(s) may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Providers may only bill one E&M service per date of service. Addressing a problem or abnormality is considered part of the global service when a preventive medicine service is performed, unless the problem or abnormality is significant enough to require additional work to meet the key components of a problem-oriented E&M service, which must be reported appropriately and separately.

Multiple E&M Services

Only one E&M service is allowed for a single date of service for the same provider group (same tax ID number) and specialty, regardless of the place of service. If multiple E&M procedure codes are submitted for a single date of service for the same provider group (same tax ID number) and specialty, the E&M procedure code with the highest allowable compensation will be processed and any additional E&M code(s) will be denied. Refer to the Compensation/Reimbursement Information section below for additional information.

Preventive Medicine Visits

If a preventive medicine procedure code (99381–99397, 99429) and a problem-focused E&M procedure code (99202–99380) are billed on the same date of service, modifier 25 should be appended to the problem-focused E&M procedure code. Refer to the Compensation/Reimbursement Information section below for additional information.

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

Antepartum Care by Same Provider Group

CarePartners of Connecticut will not routinely compensate for E&M services billed five months after a billing of 59425 or 59426 when the diagnosis is normal pregnancy and there is no intervening history of ectopic pregnancy (59100-59151) or abortion (59812-59857, S0199, S2260, S2265-S2267).

Annual Wellness Visit

CarePartners of Connecticut does not routinely compensate for the following:

- G0439 (Annual wellness visit) when billed and another annual wellness visit (G0438 or G0439) has been billed and paid in the current calendar year by any provider.
- G0438 (annual wellness visit; initial visit) when billed more than once in a member's lifetime.

CarePartners of Connecticut will not routinely compensate for G0438 or G0439 when billed by any provider greater than one unit per date of service.

Billing for Established Patients

CarePartners of Connecticut does not routinely compensate for a new patient visit when any face-to-face service has previously been billed by the same provider or a provider from the same group (same tax ID number) and same specialty within the last three years. CarePartners of Connecticut defines the same provider as those with the same provider group (same tax ID number) and same specialty.

CarePartners of Connecticut does not routinely compensate for a new patient visit when any service has previously been billed within the last three years.

Care Management and Transitional Care Management Services

CarePartners of Connecticut does not routinely compensate for care management or transitional care management (TCM) services performed within 90 days of surgery when billed by any provider.

CarePartners of Connecticut does not routinely compensate for care management services (99487, 99489, 99490) when billed more than once during the same calendar month by any provider.

CarePartners of Connecticut does not routinely compensate TCM services (99495-99496) if billed within 29 days of another TCM service, unless a discharge service has been billed by any provider in the previous 30 days.

Collaborative Care

Collaborative care services are reimbursed when provided under the direction of a treating physician or other qualified health care professional that identifies a member's behavioral health needs and integrates care management support and regular psychiatric inter-specialty consultation with the primary care team during a calendar month. When billing collaborative care services delivered during the calendar month, use the last date that the collaborative care service was performed in the month as the DOS on the claim form. Claims must be submitted after the services have been rendered in the entire month.

- **99492:** Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
- **99493:** Follow up psychiatric collaborative care management, first 60 minutes in a following month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
- **99494:** Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional directs. (use 99494 in conjunction with 99492,99493)
- **G2214:** Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

Critical Care

99291 (critical care E&M, first 30-74 minutes) will not be compensated when billed with more than one unit per day.

Diagnosis and Procedure Consistency

CarePartners of Connecticut does not routinely compensate health and behavior assessment/ intervention (96150-96155) if all ICD-CM codes on the claim line are inappropriate diagnosis/procedure combinations as defined by Regional CMS Guidelines.

Discharge Services

CarePartners of Connecticut does not routinely compensate for hospital discharge services (99238-99239) when 99238 or 99239 has been billed and paid for the subsequent date of service.

Established E&M Visits

Unless a significant, separately identifiable service was performed, CarePartners of Connecticut does not routinely separately compensate for an established patient E&M service if billed with cardiac stress tests, transthoracic echocardiography, and myocardial perfusion imaging, as the E&M service is included in those procedures.

Factors Influencing Health Status and Contact with Health Services Diagnoses and Nonroutine Examinations

CarePartners of Connecticut does not routinely compensate E&M services (excluding normal newborn care) billed with preventive medicine services (99381-99429) when reported with an ICD-10 "Z" diagnosis code as the only diagnosis on the claim.

Modifiers

CarePartners of Connecticut does not routinely compensate for E&M services when billed with modifier 24, modifier 25 or modifier 57 as outlined below.

Modifier 24: CarePartners of Connecticut does not routinely separately compensate for E&M services billed with modifier 24 if a major surgical procedure with a 90-day postoperative period has been billed in the previous 90 days and the E&M service has a primary diagnosis associated to the 90-day medical or surgical service.

Modifier 25: CarePartners of Connecticut does not routinely separately compensate for E&M services billed with modifier 25 on the same day as a procedure with a 0-, 10- or 90-day postoperative period if the member has been seen by the same provider in the last eight weeks (56 days) for the same condition. This policy applies to professional claims only.

Modifier 57: CarePartners of Connecticut does not routinely compensate E&M services with modifier 57 if billed with planned major surgical services.

CarePartners of Connecticut does not routinely compensate E&M services with modifier 57 if performed the day prior or the same day as a major surgical procedure (i.e., a procedure with a 90-day global period) and another E&M service has been billed in the previous two months and the primary diagnosis for all three services is the same.

New Patient Visits

CarePartners of Connecticut does not routinely compensate a new patient visit when any face-to-face service has previously been billed by the same provider ID (regardless of Tax ID or specialty) in the last three years.

CarePartners of Connecticut does not routinely compensate for a new patient visit when billed by a non-physician practitioner and any face-to-face service has previously been billed by the same group practice (same Tax ID, any specialty) within the last three years and the primary diagnosis on the new patient visit matches any diagnosis on the previous face-to-face service.

Observation Care Services

CarePartners of Connecticut does not routinely compensate for the following:

- Observation care discharge or hospital discharge day management when observation or inpatient hospital care, including admission and discharge on the same day, is billed the previous day.
- Observation services when billed for more than one unit per date of service in any combination by any provider and the place of service is 21 (inpatient hospital), 22 (outpatient hospital), 23 (emergency department), or 24 (ambulatory surgical center).

Place of Service Restrictions

Procedure Codes	Allowable Places of Service
99381-99397 (comprehensive preventive medicine services)	03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 26, 33, 49, 50, 71, 72
99460, 99462-99465 (Newborn care)	21, 25

Special Services, Procedures and Reports

CarePartners of Connecticut does not routinely compensate for 99050 or 99051 (Special services, provided in the office) when billed in any place of service other than 11 (Office).

Telehealth Services

Interprofessional Telephone/Internet Consultations

- 99446-99449, or 99451 (interprofessional telephone/internet consultation) are not compensated if any face-to-face service has been billed on the same date or within the previous 14 days.
- 99446-99449 or 99451 are limited in any combination to one unit in seven days.

Modifier G0

CarePartners of Connecticut does not routinely compensate for the following:

- **Professional claims:** services inappropriately billed with telehealth services modifier G0 (telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke)
- **Facility claims:** services billed with revenue code(s) 0960-0989 (professional services) that are inappropriately billed with telehealth services modifier G0

Online Digital E&M Services

- 99421-99423, 98970-98972 (online digital E&M services) are limited to one combined unit within a seven-day period
- 99421-99423 (online digital E&M services) will be denied when billed within seven days of certain other E&M services:
  - 99091 (collection and interpretation of physiologic data)
  - 99487-99489 (complex chronic care management services)
  - 99495-99496 (transitional care management services)
  - 99339-99340 (individual physician supervision of a patient [patient not present] in home, domiciliary or rest home)
  - 99374-99380 (supervision of a patient under home health, hospice, or nursing care)

Remote Physiologic Monitoring

CarePartners of Connecticut will not routinely compensate for the following:

- **99474** (separate self-measurements of blood pressure twice daily over 30-day period) if billed more than once in the same month.
- **99457** (remote physiologic monitoring treatment management services) unless 99473 or 99474 (self-measured blood pressure device services) has been billed in the previous 30 days.

Venipuncture Services

Venipuncture services will not be compensated when billed for the same DOS as an E&M service under the same provider group/tax identification number. Blood collection is considered an integral component of the E&M service and should not be separately reimbursed.

Similarly, venipuncture services performed in a facility will not be separately compensated, as they are considered an integral component of all facility fees, regardless of which other services are billed.

Note: Venipuncture services performed as the sole service (i.e., without an accompanying E&M service) will continue to be compensated.

Related Policies and Resources

- Anesthesia Professional Payment Policy
- Home Health Care Payment Policy
- Outpatient Behavioral Health and Substance Use Disorder Professional Payment Policy
- Preventive Services
- Surgery Professional Payment Policy
- Telehealth/Telemedicine Payment Policy

Document History

- November 2024; Annual policy review; added Related Policies and Resources section
- August 2024: Added collaborative care services definition and procedure codes
- November 2023: Annual policy review; administrative updates
- February 2023: Annual code updates
- November 2022: Annual policy review; administrative updates
- April 2022: Added compensation information for venipuncture services, effective for dates of service on or after June 1, 2022
- May 2021: Added claim edits for annual wellness visit, new patient visits, and special services, procedures, and reports, effective for dates of service on or after July 1, 2021; added previously communicated edit for annual wellness visit
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- November 2020: Reviewed by committee; added boiler plate language, added telehealth edits for online digital E&M services, modifier G0, interprofessional telephone/internet consultations and remote physiologic monitoring, effective for dates of service on or after January 1, 2021
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.