



Policy Memo

An Independent Licensee of the
Blue Cross and Blue Shield Association.

No. 2 OFFICE/OUTPATIENT VISIT

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 patient office visit if the above criteria have been met. This does not apply to covering arrangements.

- C. 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).
- 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.
- Administration of injections provided on same day as office visit, home visit or nursing home visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
- Items of office overhead such as malpractice insurance, telephones, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- Telephone calls or Web-based correspondence.
 - Traditional coverage - content of service when billed with another service on the same day. Not covered if billed separately and the only service rendered on that day.
 - Blue Select/Premier Blue - see Policy Memo No. 1, Section XXXIII. MANAGED CARE.

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 Policy.

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.
- Laboratory examinations and/or diagnostic x-rays.
- Administration of chemotherapy.
- 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 using modifier 22.

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. 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 post operative 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 patient visits, see Policy Memo No. 9, Section I., Paragraph B.2.