Evaluation and Management Services
## Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revisions</th>
<th>Completed By</th>
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<tbody>
<tr>
<td>1.0</td>
<td>Policies and procedures as of October 1, 2015 Published: February 25, 2016</td>
<td>New document</td>
<td>FSSA and HPE</td>
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<td>1.1</td>
<td>Policies and procedures as of April 1, 2016 Published: August 16, 2016</td>
<td>Scheduled update</td>
<td>FSSA and HPE</td>
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<td>Policies and procedures as of April 1, 2017 Published: July 18, 2017</td>
<td>Scheduled update</td>
<td>FSSA and DXC</td>
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<td>3.0</td>
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<td>Scheduled update:</td>
<td>FSSA and DXC</td>
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<td>- Reorganized and edited text as needed for clarity</td>
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<td>- Incorporated relevant information from the <em>Medical Policy Manual</em></td>
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<td>- Updated the note box at the beginning of the module</td>
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<td>- Updated links to the new IHCP website</td>
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<td>- In the <em>Introduction</em> section, added references to the <em>Dental Services</em> and <em>Podiatry Services</em> modules</td>
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<td>- In the <em>General Billing Guidelines for E/M Services</em> section, added a note about billing an E/M code on the same date as a physician-administered drug</td>
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<td>- Added EOBs to the <em>Office Visits</em> section</td>
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<td>- In the <em>Emergency Department Based Evaluation and Management Services</em> section, clarified unit limitations for nonemergency visits handled in an emergency department</td>
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<td>- Clarified information in the <em>Consultations</em> section</td>
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<td>- Added the <em>Initial and Follow-Up Inpatient Consultation</em> section</td>
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<td>- Added the <em>Consultative Pathology Services</em> section</td>
<td></td>
</tr>
</tbody>
</table>
# Table of Contents

Introduction .......................................................................................................................... 1  
General Billing Guidelines for Evaluation and Management Services .......................... 1  
Office Visits ......................................................................................................................... 2  
  Chiropractic Office Visits ................................................................................................. 2  
  Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/  
    HealthWatch Office Visits ............................................................................................. 2  
  Family Planning Eligibility Program Office Visits ....................................................... 3  
  Mental Health and Addiction Services Office Visits ..................................................... 3  
  Prenatal Office Visits ...................................................................................................... 3  
  Surgical Procedures Performed during Office Visits ..................................................... 3  
Emergency Department Based Evaluation and Management Services ....................... 3  
Inpatient Hospital Observation and Care for Evaluation and Management .................. 4  
  Hospital Discharge Services ............................................................................................ 5  
  Critical Care Services ..................................................................................................... 5  
Consultations ...................................................................................................................... 5  
  Initial and Follow-Up Inpatient Consultation ................................................................ 6  
Consultative Pathology Services ...................................................................................... 6
Introduction

Evaluation and management (E/M) services are used to assess a member’s health or condition and provide direction for the member’s healthcare. E/M services must include the following three components:

- Obtaining a medical and social history
- Conducting a physical examination
- Making a medical decision

This module provides information on medical E/M services. For information about physician-administered topical fluoride varnish, see the Dental Services module. For information regarding consultations and second opinions related to podiatry services, see the Podiatry Services module.

General Billing Guidelines for Evaluation and Management Services

For information regarding national Medicaid billing restrictions on E/M services, see the National Correct Coding Initiative module.

Note: If an E/M code is billed with the same date of service as a physician-administered drug, the provider should not bill a drug administration procedure code separately. Reimbursement for administration is included in the E/M code allowed amount. See the Injections, Vaccines, and Other Physician-Administered Drugs module for more information.
Office Visits

In accordance with Indiana Administrative Code 405 IAC 5-9-1, the Indiana Health Coverage Programs (IHCP) offers reimbursement for office visits limited to a maximum of 30 per calendar year, per member, without prior authorization (PA). The E/M Current Procedural Terminology (CPT®) codes listed in Table 1 are subject to this limitation. Additional office visits require PA and must be medically necessary. Claims for units in excess of 30 (combined total for all codes in Table 1) per calendar year without PA will be denied with explanation of benefits (EOB) 6012 – Reimbursement is limited to 30 medical services per member per rolling calendar year, unless prior authorization for additional services has been obtained.

Table 1 – Evaluation and Management CPT Codes Requiring PA after 30 Visits per Calendar Year

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>99201–99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient</td>
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<tr>
<td>99211–99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient</td>
</tr>
<tr>
<td>99381–99387</td>
<td>Initial comprehensive preventive medicine visit for the evaluation and management of a new patient</td>
</tr>
<tr>
<td>99391–99397</td>
<td>Periodic comprehensive preventive medicine visit for the reevaluation and management of an established patient</td>
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In addition, new patient office visits (99201–99205 and 99381–99397) are limited to one visit per member, per provider, within the past 3 years. For the purposes of this limitation, new patient means one patient who has not received any professional services from the provider or another provider of the same specialty and subspecialty that belongs to the same group practice. Claims in excess of this limit will be denied with EOB 6006 – New patient visits are limited to one per member, per provider, within the last three years.

Office visits should be appropriate to the diagnosis and treatment given and properly coded.

Chiropractic Office Visits

Covered chiropractic codes for office or other outpatient visits for the evaluation and management of patients are listed in the Chiropractic Services Codes, accessible from the Code Sets page at in.gov/medicaid/providers. For additional limitations related to these chiropractic office visits, see the Chiropractic Services module.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch Office Visits

See the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch module for information about billing EPSDT office visits and the office visit benefit limitation. Additional office visits, other than EPSDT screening exams, must be billed with appropriate E/M procedure codes for visits that are not full EPSDT/HealthWatch screenings, and should not be billed using Z00.121 or Z00.129 as the primary diagnosis, so that they are reimbursed accordingly.

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Family Planning Eligibility Program Office Visits

For annual and follow-up examinations for Family Planning Eligibility Program members, providers must bill the most appropriate E/M procedure code for the complexity of the examination provided. See the Family Planning Eligibility Program module for specific billing and coverage information.

Mental Health and Addiction Services Office Visits

For behavioral health office visits and related E/M coverage and billing procedures, see the Mental Health and Addiction Services module.

Prenatal Office Visits

For coverage and billing procedures related to prenatal office visits, see the Obstetrical and Gynecological Services module.

Surgical Procedures Performed during Office Visits

If a provider performs a surgical procedure during the course of an office visit, the IHCP generally considers the surgical fee to include the office visit. However, the provider may report the visit separately for the following reasons:

- The provider has never seen the member prior to the surgical procedure.
- The provider makes the determination to perform surgery during the evaluation of the patient.
- The patient is seen for evaluation of a separate clinical condition.

Providers must use the following modifiers with the E/M visit code to identify these exceptional services:

- Modifier 25 to show that there was a significant, separately identifiable E/M service by the same physician on the same day of a procedure
- Modifier 57 to show that an E/M service resulted in the initial decision to perform surgery

The medical record must include appropriate documentation to substantiate the need for an office visit code in addition to the procedure code on the same date of service.

For additional information about E/M services related to surgical procedures, see the Surgical Services module.

Emergency Department Based Evaluation and Management Services

Emergency department physicians who render emergency services to IHCP members must use the emergency department visit procedure codes (CPT codes 99281–99285) that reflect the appropriate level of screening exam.

Providers that use an emergency department as a substitute for the physician’s office for nonemergency services should bill these visits using the appropriate place-of-service code along with the E/M procedure code usually used for a visit in the office. These visits are subject to the unit limits described in the Office Visits section. The IHCP will apply a site-of-service reduction in the reimbursement, if applicable (see the Medical Practitioner Reimbursement module for additional information).
Inpatient Hospital Observation and Care for Evaluation and Management

Providers must submit professional services, such as E/M services, rendered during the course of a hospital stay on the professional claim (CMS-1500 claim form, IHCP Provider Healthcare Portal professional claim, or 837P electronic transaction). The IHCP reimburses in accordance with the appropriate professional fee schedule. The inpatient diagnosis-related group (DRG) reimbursement methodology does not provide payment for physician fees, including hospital-based physician fees.

Table 2 lists the CPT codes to be used when billing inpatient hospital observation and care for E/M of a patient, including related discharge and critical care services. The following additional guidance applies:

- The IHCP recognizes CPT codes 99234–99236 for observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service.
- When a patient is admitted to the hospital from observation status on the same date, the physician should report only the initial hospital care code (99221–99223). The initial hospital care code includes all services related to the observation status services the physician provided on the same date of an inpatient admission.
- When a patient is admitted for observation, the physician should report only the initial observation care code (99218–99220) for the first day of observation care. Subsequent care, per day of evaluation and management, should be billed using 99224–99226 for observation care or 99231–99233 for hospital care.

Table 2 – CPT Codes for Inpatient Hospital Observation and Care for Evaluation and Management

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>CPT Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>Observation and Hospital Care</td>
<td>99218–99220</td>
<td>Initial observation care, per day, for evaluation and management of a patient</td>
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<td></td>
<td>Note: Use these codes for the first day of observation care for patients admitted for observation or inpatient care and discharged on a different date.</td>
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<tr>
<td></td>
<td>99221–99223</td>
<td>Initial hospital care, per day, for the evaluation and management of a patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Use these codes for the first day of hospital care for patients admitted for observation or inpatient care and discharged on a different date.</td>
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<tr>
<td></td>
<td>99224–99226</td>
<td>Subsequent observation care, per day for the evaluation and management of a patient</td>
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<tr>
<td></td>
<td>99231–99233</td>
<td>Subsequent hospital care, per day for the evaluation and management of a patient</td>
</tr>
<tr>
<td></td>
<td>99234–99236</td>
<td>Observation or inpatient hospital care for evaluation and management of a patient including admission and discharge on the same date</td>
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<td></td>
<td>Note: Use these codes to report services to a patient designated as “observation status” or “inpatient status” and discharged on the same date as admission.</td>
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### Hospital Discharge Services

Providers should report inpatient hospital discharge day management by using CPT code 99238 or 99239, depending on the amount of time spent discharging the patient. Providers should document the amount of time in the medical record to substantiate the code being billed. For hospital observation discharges, which means the patient was not admitted, CPT code 99217 should be used.

For a patient admitted and discharged from observation or inpatient status on the same date, report the service using CPT codes 99234–99236.

Providers should report separately, using CPT codes 99217, 99238, or 99239, for hospital discharge services performed on the same day as a nursing facility admission by the same provider.

### Critical Care Services

The IHCP recognizes CPT codes 99291–99292 for reporting critical care services performed by a physician. The IHCP has adopted the guidelines set forth in the CPT manual, and providers can find a complete definition of critical care services in the current version of the CPT manual.

### Consultations

A consultation is a type of service provided by a physician whose medical opinion about evaluation and management of a member’s specific condition is requested by another physician or other appropriate healthcare professional. A consultation requires collaboration between the requesting and consulting physician. It requires the consulting physician to examine the patient, unless the applicable standard of care does not require a physical examination. In accordance with 405 IAC 5-8-3(a), evaluation of a self-referred or non-physician-referred patient is not considered a consultation because a consultation requires collaboration between the requesting and the consulting physician.
The IHCP does not cover consultation CPT codes 99241–99245 (patient office consultation) or 99251–99255 (inpatient consultation). Although these patient consultation codes are noncovered, consultation visits remain a covered service under applicable E/M codes, including but not limited to:

- 99201–99205 for new patient office and other outpatient visits
- 99211–99215 for established patient office and other outpatient visits
- 99221–99223 for initial hospital care visits
- 99231–99233 for subsequent hospital care visits

Providers should report each E/M service, including visits that could be described by patient consultation codes, with an E/M code that represents where the visit occurred and that identifies the complexity of the visit performed.

A physician consultant may initiate diagnostic or therapeutic services.

**Initial and Follow-Up Inpatient Consultation**

IHCP reimbursement for an *initial* consultation is limited to one per consultant, per member, per inpatient hospital or nursing facility admission.

IHCP reimbursement is available for *follow-up* inpatient consultations when additional visits are needed to complete the initial consultation, or if subsequent consultative visits are requested by the attending physician. These consultative visits include monitoring progress, recommending management modifications, or advising on a new plan of care (POC) in response to changes in the patient’s status. If the inpatient consulting physician initiated treatment at the initial consultation and participates thereafter in the patient’s management, the codes for subsequent hospital care should be used.

**Consultative Pathology Services**

Consultative pathology laboratory services are reimbursable if they meet the following criteria:

- The member’s attending physician requested the service in writing
- The consult relates to a test result that lies outside the clinically significant normal or expected range in view of the condition of the member.
- The consultant provides a written narrative report to be included in the member’s medical record.

Medical judgment is required by the consulting physician.