INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Evaluation and Management Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: August 16, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of April 1, 2017 Published: July 18, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of August 1, 2018 Published: January 24, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of August 1, 2019 Published: September 26, 2019	Scheduled update: • Edited text as needed for clarity • Modified the initial note box with standard wording • Added a reference to the *Dental Services* module in the *Introduction* section, for dental evaluation and management • Added a reference to the *Laboratory Services* module in the *Consultations* section • Added the *Confirmatory Consultation* section • Removed the *Consultative Pathology Services* section	FSSA and DXC

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Evaluation and Management Services

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.*

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 **dental** evaluation and management, including dental consultations, see the *Dental Services* module. (Note that the *Dental Services* module also contains information about physician-administered topical fluoride varnish.)

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®[1]) 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.*

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

CPT Code	Description
99201–99205	Office or other outpatient visit for the evaluation and management of a new patient
99211–99215	Office or other outpatient visit for the evaluation and management of an established patient
99381–99387	Initial comprehensive preventive medicine visit for the evaluation and management of a new patient
99391–99397	Periodic comprehensive preventive medicine visit for the reevaluation and management of an established patient

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.

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.

Evaluation and Management Services Rendered in an Emergency Department

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

The inpatient diagnosis-related group (DRG) reimbursement methodology does not provide payment for physician fees, including hospital-based physician fees. Therefore, providers must submit professional services – including E/M services – that are 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 these services in accordance with the Professional Fee Schedule.

Table 2 lists the CPT codes to be used when billing inpatient hospital observation and care for evaluation and management 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

Type of Service	CPT Codes	Description
Observation and Hospital Care	99218–99220	Initial observation care, per day, for evaluation and management of a patient *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.*
	99221–99223	Initial hospital care, per day, for the evaluation and management of a patient *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.*
	99224–99226	Subsequent observation care, per day for the evaluation and management of a patient
	99231–99233	Subsequent hospital care, per day for the evaluation and management of a patient
	99234–99236	Observation or inpatient hospital care for evaluation and management of a patient including admission and discharge on the same date *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.*

Type of Service	CPT Codes	Description
Hospital Discharge	99217	Observation care discharge day management *Note: This code is to be used to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for observation or inpatient care services including admission and discharge services (99234–99236) as appropriate.*
	99238–99239	Hospital discharge day management *Note: Use these for patients admitted for observation or inpatient care and discharged on a different date.*
Critical Care	99291–99292	Critical care, evaluation and management of the critically ill or critically injured patient

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. The consulting physician may initiate diagnostic or therapeutic services.

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.

For information about consultative pathology services, see the *Laboratory Services* module.

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.

Confirmatory Consultation

A confirmatory consultation to substantiate medical necessity may be required as part of the prior authorization process. The consultation may be billed only when it is specifically requested by another physician or IHCP contractor for the purpose of rendering a second or third medical opinion, completed by a physician for a specific member.

Podiatrists may be required to obtain confirmatory consultations for certain surgical procedures, as described in the *Podiatry Services* module.