



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Evaluation and Management Services

LIBRARY REFERENCE NUMBER: PROMOD00026
PUBLISHED: JULY 18, 2017
POLICIES AND PROCEDURES AS OF APRIL 1, 2017
VERSION: 2.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures current as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures current as of April 1, 2016 Published: August 16, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures current as of April 1, 2017 Published: July 18, 2017	Scheduled update: <ul style="list-style-type: none"> • Reorganized text for clarity • Added <i>Introduction</i> section • Added Portal billing as an option to claim submission method • Added the <i>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch Services</i> section • Updated the <i>Consultations</i> section 	FSSA and DXC

Table of Contents

Introduction	1
Coverage and Billing Procedures for E/M Services	1
Chiropractic Codes for Office Visits	2
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch Services.....	2
Emergency Services Screening Examination Codes.....	2
Family Planning Eligibility Program E/M Codes	2
Mental Health and Addiction E/M Services	2
Prenatal Office Visits.....	2
Surgical Procedures Performed during Office Visits	3
Consultations.....	3
Hospital Observation or Inpatient Care Services	3
Hospital Discharge Services	5
Critical Care Services	5

Evaluation and Management Services

Note: For policy information regarding coverage of evaluation and management services, see the [Medical Policy Manual](#) at [indianamedicaid.com](#).

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

Coverage and Billing Procedures for E/M Services

Per *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 IHCP member, without prior authorization (PA), and subject to the restrictions in *405 IAC 5-9-2*. The E/M services Current Procedural Terminology (CPT^{®1}) codes listed in Table 1 are subject to these limitations. Additional office visits require PA and must be medically necessary. Per *405 IAC 5-9-2(a)*, office visits should be appropriate to the diagnosis and treatment given and properly coded.

Table 1 – Evaluation and Management Services CPT Codes Requiring PA after 30 Visits per Member 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

Providers must submit professional services rendered during the course of a hospital confinement on the *CMS-1500* claim form or electronic equivalent (837P electronic transaction or Provider Healthcare Portal professional claim). 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.

New patient office visits are limited to one visit per member, per provider, within the past three years. For the purposes of this document, *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.

¹ CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

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 a CPT code usually used for a visit in the office. The IHCP will apply a site-of-service reduction in the reimbursement, if applicable. See the [Medical Practitioner Reimbursement](#) module for additional information.

For information regarding national Medicaid billing restrictions on evaluation and management services, see the [National Correct Coding Initiative](#) module.

Chiropractic Codes for 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* on the [Code Sets](#) page at indianamedicaid.com.

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

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.

Emergency Services Screening Examination Codes

Emergency department physicians who render emergency services to IHCP eligible members must use procedure codes that reflect the appropriate level of screening exam, as shown in the *Emergency Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

Family Planning Eligibility Program E/M Codes

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 information about the program. For a list of appropriate E/M codes, see the *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com.

Mental Health and Addiction E/M Services

For behavioral 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.

Consultations

A consultation is a type of service provided by a physician whose opinion or advice about evaluation and management of a specific problem is **requested by another physician or other appropriate source**. A physician consultant may initiate diagnostic or therapeutic services. Evaluation of a self-referred or non-physician-referred patient is not considered a consultation because a consultation implies collaboration between the requesting and the consulting physician.

The IHCP does not cover CPT consultation codes 99241–99245 or 99251–99255. Although consultation codes are noncovered, office consultation remains 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 CPT consultation codes, with an E/M code that represents where the visit occurred and that identifies the complexity of the visit performed.

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.

Hospital Observation or Inpatient Care Services

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 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.

Table 2 – CPT Codes for Inpatient Hospital Observation and Care for E/M

CPT Code	Description
Observation and Hospital Care Services	
99218–99220	Initial observation care, per day, for evaluation and management of a patient <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <i>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.</i> </div>
99221–99223	Initial hospital care, per day, for the evaluation and management of a patient <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <i>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.</i> </div>
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 <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <i>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.</i> </div>
Hospital Discharge Services	
99217	Observation care discharge day management <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <i>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.</i> </div>

CPT Code	Description
99238–99239	Hospital discharge day management <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <i>Note: Use these for patients admitted for observation or inpatient care and discharged on a different date.</i> </div>
Critical Care Services	
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.