INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Evaluation and Management Services

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Version	Date	Reason for Revisions	Completed By
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1.1	Policies and procedures as of April 1, 2016 Published: Aug. 16, 2016	Scheduled update	FSSA and HPE
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7.0	Policies and procedures as of Feb. 1, 2023 Published: June 2, 2023	Scheduled update: • Reorganized and edited text as needed for clarity • Added a reference for telehealth E/M services in the *Introduction* section • Updated the *Components of Evaluation and Management Code Selection* section • Updated the *Prolonged Office or Other Outpatient E/M Services* section • Updated the *Hospital Inpatient and Observation Care for Evaluation and Management* section • Updated the *Hospital Discharge Services* section • Updated codes in the *Consultations* section	FSSA and Gainwell

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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 IHCP 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.

For information about E/M services performed as telehealth, see the *Telehealth and Virtual Services* module.

> *Note: If an E/M code is billed with the same date of service as a physician-administered drug (other than a vaccine provided through the Vaccines for Children program), 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.*

Components of Evaluation and Management Code Selection

In accordance with new and revised guidelines released in 2021 and 2023 from the American Medical Association (AMA) and the Centers for Medicare & Medicaid (CMS), for most categories of E/M services (including office visits, inpatient and observation care, nursing facility services, and home and residential services), the E/M level is determined using **either** of the following components:

- A new medical-decision-making (MDM) matrix; see the *CPT E/M Office Revisions Level of Medical Decision Making* table, accessible from the AMA website at ama-assn.org
- Total time spent by the physician and/or other qualified healthcare professionals on the date of the encounter for activities including the following:
  - Preparing for the visit (for example, reviewing test results)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically necessary examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering tests, medications, prescriptions or procedures after the visit
  - Referring and communicating with other healthcare professionals (when not reported separately)
  - Documenting clinical information in the patient's medical record
  - Independently interpreting results (not separately reportable) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reportable)

> *Note: Although performing a medically appropriate history and/or examination does contribute to both the time spent and the level of medical decision making, these elements alone should not determine the appropriate code level for the service. Nonetheless, it is still very important to include a medically appropriate history and/or examination. This is needed for each encounter for the continuity of care and to clearly identify the status of the patient, among other reasons.*
>
> *As a reminder, when using total time, the time listed in the descriptor **must** meet or exceed the time listed for the code billed. As a best practice, when the duration of a visit exceeds the normal time for a visit, a qualification statement would be useful for coders and payors. This statement might include what the time was spent doing or why that amount of time was needed.*

Details are available on the *CPT® Evaluation and Management* page at ama-assn.org. Providers should review these changes and base coding decisions on the guidance offered by the AMA.

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.*

[1] *CPT copyright 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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

CPT Code Range	General Description
99202–99205	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 (99202–99205 and 99381–99387) are limited to one visit per member, per provider, within the past three 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, as described in the *Components of Evaluation and Management Code Selection* section.

Note: For information regarding office visits for specific types of services (such as obstetric or behavioral health care), by certain provider specialties (such as chiropractor, podiatrist or optometrist), or within certain programs (such as the Family Planning Eligibility Program), see the appropriate provider reference module on the IHCP Provider Reference Modules page at in.gov/medicaid/providers.

In accordance with the Indiana Administrative Code (IAC), podiatrists and chiropractors are ineligible for reimbursement for detailed or comprehensive visits (99204, 99205, 99214 or 99215). The IHCP continues to review any possible policy changes regarding updates to these provider specialty code sets.

Prolonged Office or Other Outpatient E/M Services

The following add-on codes may be used to report a prolonged service only when the visit code selection is based primarily on time and only after the total time of the highest-level service (99205 or 99215) has been exceeded by 15 minutes:

- G2212 – *Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)*
- 99417 – *Prolonged outpatient service, each 15 minutes of total time beyond required time of primary service*

The applicable add-on code (G2212 or 99417) should be listed separately, in addition to CPT code 99205 or 99215. Medical necessity must be documented in the medical record to substantiate the reason reimbursement should be allowed for the prolonged visit or encounter.

Providers cannot bill both G2212 and 99417 for the same visit. The IHCP reimburses these procedure codes at the same rate.

Prolonged service add-on codes are not used if the visit code is selected primarily using the MDM matrix.

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.

Nursing Facility Visits

For members residing in nursing facilities, reimbursement for E/M visits to the facility is limited to one per 27 days, unless documentation supporting the need for additional visits is included with the claim. See Table 2 for applicable codes.

Table 2 – Nursing Facility Visit CPT Codes Limited to One per 27 Days Without Documentation of Need

CPT Code	Description
99304–99306	Initial nursing facility visit
99307–99310	Subsequent nursing facility visit
99318	Nursing facility annual assessment
99324–99328	New patient assisted living visit

If a member requires more than one of the services in Table 2 during the same 27-day period, providers must include a claim note or attachment when billing the second and subsequent services. The note should include documentation supporting the need for more than one nursing facility visit per 27 days, such as the treatment of emergent, urgent or acute conditions or symptoms with a new diagnosis code.

See the *Claim Submission and Processing* module for more information on claim notes.

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).

Hospital Inpatient and Observation 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, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Table 3 lists the CPT codes to be used when billing hospital inpatient and observation care for evaluation and management of a patient, including related discharge and critical care services. The following additional guidance applies:

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

> *Note: Observation care is not considered an inpatient service. If the patient is in observation, the E/M services submitted on the professional claim should indicate an outpatient place of service (POS) code.*

Table 3 – CPT Codes for Hospital Inpatient and Observation Care for Evaluation and Management

Type of Service	CPT Code	Description
Observation and Hospital Care	99221–99223	Initial hospital care, per day *Note: Use these codes for the **first day** of hospital/observation care for patients admitted for observation or inpatient care and discharged on a **different date**.*
	99231–99233	Subsequent hospital care, per day
	99234–99236	Initial hospital care with same-day admission and discharge *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.*
Hospital Discharge	99238, 99239	Hospital discharge day management *Note: These codes are to be used to report all services provided to a patient on the date of discharge, if that date is different from the initial date of inpatient/observation status. If the patient is admitted and discharged on the same date, the appropriate 99234–99236 code should be used.*
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 dates of service on or after Jan. 1, 2023, these discharge codes apply regardless of whether the patient being discharged from observation care or from inpatient care, as long as the discharge is not on the same date as the admission.

For a patient discharged from observation or inpatient status *on the same date as they were admitted to the hospital*, report the discharge service using CPT codes 99234–99236.

If a patient is discharged from a hospital and is then admitted to a nursing facility on that same date by the same provider, the provider should separately report both services, as follows:

- If the patient is discharged on a different day than initial admittance (or initiation of observation status), and is then admitted to a nursing facility on that same day by the same provider, then the appropriate discharge CPT code (99238 or 99239) should be reported separately from the nursing facility admission.
- If a patient is discharged on the same day as initial admittance (or initiation of observation status), and is then admitted to a nursing facility on that same day by the same provider, then the appropriate discharge CPT code (99234–99236) should be reported separately from the nursing facility admission.

Critical Care Services

The IHCP recognizes CPT codes 99291 and 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 99242–99245 (office/outpatient consultation) or 99252–99255 (hospital/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:

- 99202–99205 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.