519.2 EVALUATION AND MANAGEMENT SERVICES

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519.2 EVALUATION AND MANAGEMENT SERVICES

BACKGROUND

The West Virginia Bureau for Medical Services (BMS) offers a comprehensive scope of medically necessary medical, dental, and mental health services. All covered and authorized services must be provided by enrolled providers.

POLICY

519.8.1 COVERED SERVICES

Evaluation and Management (E&M) services involve face-to-face contact between members and physicians, or other qualified healthcare professionals. This policy addresses the following group of providers: physicians, physician assistants (PAs), and advanced practice registered nurses (APRNs) practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all state and federal requirements. Contact may occur in a hospital setting, the practitioner's office, other ambulatory settings, emergency departments, long-term care facilities, or in the member's home. Practitioners must verify member eligibility before services are provided.

The West Virginia Medicaid coverage of (E&M) services is outlined below:

- The (E&M) current procedural terminology (CPT) code must reflect the content of the service.
- Only one evaluation and management CPT code is covered on the same date of service per member per practitioner.
- Only one (E&M) procedure may be billed when more than one practitioner, in the same specialty and same group, provides a service to the same member on the same date of service, unless the (E&M) services are for unrelated problems.
- When multiple (E&M) visits occur on the same date of service, the practitioner must bill with the appropriate (E&M) CPT code that best represents the combined level of service.
- The medical record must chronologically report the member's care and record-related facts, findings, and observations about the member's health history. The record must be individualized and document and support the level of evaluation and management care provided. At a minimum, the documentation must contain the following:
    - The billed procedure code components, based on CPT code guidelines.
    - The time the practitioner spent with the member for medical decision making.
    - The coordination of care or counseling provided, including face-to-face contact time when time is the key component for CPT code selection.
    - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results.
    - Assessment, clinical impression, or diagnosis.
    - Medical plan of care.
    - Date of service and rationale for ordering diagnostic and other services.
    - Member's appropriate health risk factors.
    - Member's progress, response to and changes in treatment.

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E&M add-on code documentation must clearly separate the additional service from the standard evaluation and management evaluation and management section in the medical record. Documentation must contain details of the specific time spent on the add-on service, the nature of the service provided, and any relevant interventions or modalities used, ensuring it's identifiable as a distinct service beyond the regular evaluation and management visit.

Documentation must be member-specific, visit specific and legible. Errors in documentation cannot be completely covered over, but should be indicated with a line through the error and noted/initialed by the person making the correction.

The BMS follows the Centers for Medicare and Medicaid Services' (CMS) decision to no longer accept the consultation CPT codes. E&M visit codes have replaced consultation codes.

519.8.1.1 Preventive Care Services

The BMS covers well-child preventive medical examinations for children up to 21 years of age based on the recommended periodicity schedule established by the American Academy of Pediatrics (AAP) and Bright Futures, and adopted by West Virginia's Medicaid-mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

For adult members, the BMS covers annual physical examinations and other preventive and diagnostic services. The annual exam must be reported with a preventive medicine CPT code reflective of the member's age.

Eligibility examinations requested by a West Virginia Department of Human Services (DoHS) local countuy office for the purpose of determining Medicaid eligibility are not billed as annual physicals.

519.8.1.2 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

West Virginia's EPSDT Program offers screenings and other preventive health services at regularly scheduled intervals to members less than 21 years of age, based on the recommended frequency established by the AAP Bright Futures Guidelines. These services target early detection of disease and illness to correct or ameliorate a physical or mental condition and provide referral of members for necessary diagnostic and treatment services.

Per AAP/Bright Futures Guidelines, EPSDT services include a physical examination, developmental, hearing, vision, and dental screenings. The provider must document the medical necessity for the service during the EPSDT exam or screening. Interperiodic screenings are also covered at any visit outside the AAP/Bright Futures periodicity schedule. These may be provided by any enrolled Medicaid practitioner within their scope of practice, as appropriate for the type of screening.

Medicaid members up to 21 years of age may be referred for further diagnostic and treatment services as a result of an EPSDT exam. The need for the additional service(s) must be documented in an age-appropriate health record completed on the date the need was identified. The health record and clinical documentation that supports medical necessity of the additional service must be submitted to the BMS

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utilization management contractor (UMC) or the member's managed care organization (MCO). The date of the health record and clinical documentation must not exceed six months from the date of the service request. Any specialist providing services should coordinate service needs with the primary care provider (PCP). Providers must make reasonable efforts to determine if members are referred to their office as a result of an EPSDT exam by asking the referring provider, clinic, or member.

If a member is ill on the scheduled EPSDT screening date and all required components are completed and documented, the practitioner must bill the age-appropriate preventive care CPT code. If a member is ill on the scheduled EPSDT screening date and the practitioner cannot complete all required components, the practitioner must document the treatment provided in the individual's medical record and bill the appropriate E&M CPT code for the actual service provided. It is the responsibility of the practitioner to reschedule the member to complete the screening as soon as possible.

519.8.1.3 Services Provided in a Nursing Facility

Refer to *Chapter 514, Nursing Facility Services* for additional information.

519.8.1.4 Second Opinion for Diagnosis & Treatment

Provider or member iniatiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures are covered. In the event that the recommendation of the first and second provider differ regarding the need for surgery or other major procedure, a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. The physician must bill the appropriate E&M CPT code, as well as document the type of service and the name of the member or physician requesting the second opinion.

519.8.1.5 Prolonged Physician Attendance

The BMS covers prolonged medical services by a physician in face-to-face attendance with the member. This service must exceed the initial threshold time for the E&M service rendered. Documentation of prolonged services, to include duration of direct attendance, must be included in the member's medical record. This duration does not need to be continuous; however, it must be provided on the same date of service.

Prolonged services in the hospital setting, time spent waiting for specific events to occur (i.e., test results, changes in the member's condition, therapy to end, or use of facilities), are not covered. Additionally, time spent by office staff with the member, or time the member was unaccompanied in the office, is not included in the total time, and is not reimbursable.

Prolonged service CPT codes require companion E&M code(s) when the same physician provides both types of services on the same date of service to the same member.

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519.8.1.6 Medicaid Eligibility Examinations

The West Virginia DoHS local county office requests physical examinations and reports on pending applications for the purpose of determining Medicaid eligibility. Based on Social Security disability regulations, eligibility examinations may only be performed by a medical doctor (MD) or a doctor of osteopathy (DO). Only one eligibility examination E&M procedure code may be reimbursed per provider. Diagnostic services may be ordered by the examining physician if medically necessary to complete the examination. The documentation of the authorization, examination, medical necessity for diagnostic procedures, and diagnostic findings must be maintained in the member's record. Eligibility examinations are not reimbursed by the Medicaid MCOs.

Refer to the Bureau for Family Assistance Income Maintenance Manual for more information.

519.8.1.7 Observation Care

Observation care is defined as the use of a bed and periodic monitoring by hospital nursing or other indicated staff at the level and frequency necessary to evaluate the member's condition to determine the need for inpatient admission.

The maximum time limit in an observation area is 48 hours, and only the initial and discharge observation care is covered for reimbursement. Furthermore, if the member is admitted as an inpatient to the hospital from the observation area, the hospital admission requires prior authorization by the appropriate UMC. If the admission is approved, the physician is still eligible for reimbursement of their service to the member in the initial and discharge observation care. The observation care is included in the hospital prior authorization process to permit reimbursement to the facility.

When a member is admitted to observation subsequent to a hospital service, the admitting physician must be physically present on the hospital premises. If a member is examined by a practitioner other than the admitting physician while in observation, that practitioner must bill the outpatient E&M code appropriate for the service provided.

The criteria for observation services include the following basic provisions:

- Observation services are covered only upon written order of a physician. This order must document the medical necessity for the services and is retained as part of the patient's medical record. Documentation requirements for admission to observation are essentially the same as for inpatient admission; however, the medical necessity criteria are less stringent.
- Observation does not require prior authorization.
- Coverage of observation may not exceed 48 hours.
- Observation services are appropriate for labor and delivery monitoring when the medical necessity criteria are met.

519.8.1.8 Services Provided in an Inpatient Acute Care Hospital Setting

As with other E&M services, only one hospital visit per date of service is covered regardless of how many

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times a practitioner sees the member on that date.

519.8.1.9 Office Visits and Other Outpatient Services

An office visit associated with a covered procedure or minor surgery performed in a practitioner's office is considered part of the procedure and is not separately payable by Medicaid. The visit may be billed separately, with the appropriate modifier, provided the visit is for a distinctly different reason.

A visit to a practitioner's office or outpatient department of a hospital solely for a diagnostic service does not qualify for coverage or payment as an E&M service. Medicaid payment shall be made for the diagnostic service, but not for the visit as it is bundled with the payment for the diagnostic service.

A preoperative visit and follow-up care are bundled with the payment for the surgery and are not separately reimbursed. However, follow-up care may be reimbursed to other practitioners, such as an optometrist providing follow-up care for an ophthalmologist.

Services provided by behavioral health providers including, but not limited to, private psychiatrists; psychologists; psychiatric APRNs; Licensed Behavioral Health Centers; federally qualified health centers, and rural health centers are addressed in other chapters of the BMS Provider Manual.

519.8.2 Non-Covered Services

E&M and Observation services not reimbursed by the BMS include, but are not limited to:

- Visits related to a service not covered by the BMS;
- Visits covered under a global surgical fee;
- Outpatient observation on the same date as discharge from inpatient facility;
- Observation services billed in conjunction with therapeutic services such as chemotherapy, or labor and delivery;
- Observation which extends into hospital admission;
- Standing orders for specialist visits are not accepted.

Non-Covered services are not eligible for West Virginia DoHS Fair Hearings or Desk/Document Reviews.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

REFERENCES

West Virginia State Plan references physician services at sections 3.1-A(5)(a), 3.1-B(5)(a), supplement 2 to attachments 3.1-A and 3.1-B(5)(a) and reimbursement at 4.19-B(5).

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West Virginia State Plan references gerontological and pediatric and family nurse practitioner services at sections 3.1-A(6)(d) and (23), 3.1-B(6)(d) and (23), supplement 2 to attachments 3.1-A and 3.1-B(6)(d) and (23).

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Evaluation and Management Services	January 15, 2016
Entire Chapter	Changes were made to 519.8.1 Covered Services to remove certain restrictions on APRN covered services	May 18, 2018
Entire Chapter	519.8.1 Added medical record documentation requirements 519.8.1.2 Clarified EPSDT language	January 1, 2025

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