



519.8 EVALUATION AND MANAGEMENT SERVICES

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519.8 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 health care professionals. This policy addresses the following group of providers: physicians, physician assistants, and advanced practice registered nurse (APRN) 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 CPT code must reflect the content of the service.
- Only one E&M 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 member's medical record must document and support the level of E&M 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.

The West Virginia 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 West Virginia 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 West Virginia 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.

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Eligibility examinations requested by a West Virginia county Department of Health and Human Resources (DHHR) 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 American Academy of Pediatrics (AAP) and Bright Futures. 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, and 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 his/her 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 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

West Virginia Medicaid covers one nursing facility practitioner visit per 30 days when made by the member's PCP (i.e. Medical Director of the nursing facility). The appropriate E&M CPT code must be used to bill for the visit. West Virginia Medicaid does not reimburse a nursing facility visit if the same physician provides another E&M visit to the same member on the same date of service.

According to [42 CFR 483.40](#), a physician must personally approve, in writing, a recommendation that a person be admitted to a nursing facility. The administrator or designee must ensure that each resident's medical care is supervised by a physician at all times. If the attending physician is unavailable, another physician must supervise the medical care of the residents.

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Specialist services, including but not limited to those provided by a dentist, podiatrist, or an optometrist, must be provided based on a physician's order written by the PCP. Standing orders for specialist visits are not accepted. The specialist must bill the appropriate CPT code for their services.

Refer to [Chapter 514, Nursing Facility Services](#) for additional information.

519.8.1.4 Second Opinion for Diagnosis & Treatment

Second opinions requested by a member or physician are covered for medically necessary diagnosis and treatment. The intent is to allow a member to seek additional information to make better informed decisions regarding health care. 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 West Virginia 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.

519.8.1.6 Medicaid Eligibility Examinations

The local West Virginia DHHR 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). One eligibility examination E&M procedure code must 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 Managed Care Organizations (MCOs).

Refer to the [WV DHHR Bureau for Children and Families 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.

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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 BMS UMC. If the admission is approved, the physician is still eligible for reimbursement of his/her 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 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; FQHCs; and RHCs are addressed in other chapters of the [BMS Provider Manual](#).

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519.8.2 NON-COVERED SERVICES

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

- Visits related to a service not covered by the West Virginia 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 DHHR 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\(5\)](#).

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