

Evaluation and management services are a benefit of the Texas Medicaid Program. Evaluation and management services are divided into a broad set of categories and subcategories (e.g., outpatient services, inpatient services). Medical documentation for evaluation and management services must consist of the appropriate components (e.g., history, physical exam, medical decision making) as designated in the 1995 and 1997 Physician Evaluation and Management guidelines as published by the Center for Medicare and Medicaid Services and Current Procedural Terminology (CPT) manual.

Office or Other Outpatient Services

Outpatient services are defined as services rendered in an outpatient setting such as a physician office, ambulatory facility, and/or other outpatient settings.

New and Established Patient Services

Effective for dates of service on or after May 1, 2007, new patient visits will be allowed every three years for physician evaluation and management services, per patient, per provider.

According to the CPT, a new patient is defined as one who has not received any professional services from a physician or physician within the same group practice of the same specialty, within the past three years. An established patient is one who has received professional services from a physician or physician within the same group practice of the same specialty, within the last three years.

Providers may utilize procedure codes 1-99201, 1-99202, 1-99203, 1-99204, and 1-99205 when billing for new patient services provided in the office, in an outpatient, or other ambulatory facility. Providers may utilize procedure codes 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215 when billing for established patient services provided in the office, or in an outpatient or other ambulatory facility.

If an established patient visit is billed on the same day as a new patient visit in any setting by the same provider for any diagnosis, the established patient visit will be denied as part of another procedure on the same day. New or established patient care visits are limited to one per day for the same provider regardless of diagnosis.

Office visits (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215) provided on the same day as a planned procedure (minor or extensive), are included in the cost of the procedure and are not reimbursed separately. An office visit provided for a separately identifiable service on the same day as a planned procedure, is considered for reimbursement with medical documentation. The modifier 25 should be appended to the evaluation and management code to indicate that the evaluation was provided for a separately identifiable service.

Procedures inclusive to evaluation and management services will be denied as part of another procedure when billed on the same day, by the same provider, as an office (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215) or outpatient consultation (3-99241, 3-99242, 3-99243, 3-99244, and 3-99245) visit.

Charges for inconvenience or after-hours services (1-99050, 1-99056, or 1-99060), by emergency department-based physicians or emergency department-based groups, are not allowed.

Preventive Care Visits

Preventive health visits are available under the Texas Medicaid Program as follows:

- Texas Health Steps (THSteps) preventive health visits (medical checkups) are available for clients birth to 21 years of age
- Women's health - breast exams, Pap smears

When a patient office visit is billed on the same day as a THSteps medical check-up or exception to periodicity visit, the office visit must be billed as an established patient visit. If a new patient visit is billed on the same day as THSteps medical check-up or exception to periodicity visit, then the new patient visit will be denied.

Emergency Department Services

Emergency department procedure codes (1-99281, 1-99282, 1-99283, 1-99284, and 1-99285) are used to describe evaluation and management services provided in the emergency department to new or established patients.

If an emergency department visit (1-99281, 1-99282, 1-99283, 1-99284, and 1-99285) is billed on the same day, by the same provider, as an office visit (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215), outpatient consultation (3-99241, 3-99242, 3-99243, 3-99244, and 3-99245), or nursing facility service (1-99304, 1-99305, 1-99306, 1-99307, 1-99308, 1-99309, and 1-99310), the emergency department visit may be considered for reimbursement, and the office, consultation, and/or nursing facility visit is denied.

Emergency department visits (1-99281, 1-99282, 1-99283, 1-99284, and 1-99285) will be denied when billed on the same day as an observation service (1-99217, 1-99218, 1-99219, and 1-99220) by the same provider.

Multiple emergency department visits on the same day, billed by the same provider, must have the times for each visit documented on the claim form, or more than one visit on the same day can be indicated by adding the modifier 76 to the claim form. Medical documentation is required to support this charge.

Critical care provided on the same day as an emergency room visit may be billed when the services are rendered during a separate encounter. Medical documentation is required to support this charge.

Services Outside of Business Hours

Texas Medicaid limits reimbursement for after-hours charges (1-99050, 1-99056, and 1-99060) to office-based providers rendering services after routine office hours and/or on an emergency basis.

An office-based provider may bill an after-hours charge in addition to a visit for providing services after his/her routine office hours. This should be billed when a provider, in his/her clinical judgment, deems it medically necessary to interrupt his/her schedule to care for a patient with an emergent condition. A provider's routine office hours are those hours posted at the physician's office as the usual office hours. Texas Medicaid reimburses office-based physicians an inconvenience charge when either of the following exists:

- The physician leaves the office or home to see a client in the emergency room; or
- The physician leaves the home and returns to the office to see a client after the physician's routine office hours; or
- The physician is interrupted from routine office hours to attend to another client's emergency outside of the office.

Charges for inconvenience or after-hours services, by emergency department-based physicians or emergency department-based groups, are not reimbursed separately.

Observation Services

Hospital observation services (1-99217, 1-99218, 1-99219, and 1-99220) is for professional services for a period of more than 6 hours, but fewer than 24 hours, regardless of the hour of the initial contact, whether or not the patient remains under physician care beyond midnight.

Observation may take place in any patient care area of the hospital or outpatient setting.

Observation care discharge day management may be billed to report services provided to a patient upon discharge from "observation status" if the discharge is on a day other than the initial date of admission. Procedure codes 1-99211, 1-99212, 1-99213, 1-99214, 1-99215, 1-99218, 1-99219, and 1-99220 will be denied if billed on the same day as procedure codes 1-99217, 1-99234, 1-99235, and 1-99236 by the same provider. Evaluation and management services provided in any place of service other than the inpatient hospital, billed on the same day as a physician observation visit, by the same provider, will be denied.

If a physician observation visit (1-99217, 1-99218, 1-99219, 1-99220, 1-99234, 1-99235, and 1-99236) is billed on the same day as prolonged services (1-99354 and 1-99355) by the same provider, the prolonged services will be denied as part of another procedure on the same day.

If dialysis treatment and physician observation visits are billed the same day, by the same provider, same specialty, other than nephrology and internal medicine specialists, the dialysis treatment will be paid, and the physician observation visit will be denied.

Prolonged Physician Services

Prolonged services may be provided in the office, outpatient, or inpatient setting and involve direct (face-to-face) patient contact that is beyond the usual service and exceeds the time threshold of the evaluation and management code (1-99201, 1-99202, 1-99203, 1-99204, 99205, 1-99211, 1-99212, 1-99213, 1-99214, 1-99215, 1-99221, 1-99222, 1-99223, 1-99231, 1-99232, 1-99233, 3-99241, 3-99242, 3-99243, 3-99244, 3-99245, 3-99251, 3-99252, 3-99253, 3-99254, 3-99255, 1-99341, 1-99342, 1-99343, 1-99344, 1-99345, 1-99347, 1-99348, 1-99349, and 1-99350) being billed on that day.

- Procedure codes 1-99354 and 1-99356 should be used in conjunction with the evaluation and management code to report the first hour of prolonged service and will be limited to one per day.
- Procedure codes 1-99355 and 1-99357 should be used to report each additional 30 minutes and will be limited to a quantity of three units or one-and-one-half hours per day.
- Prolonged services of fewer than 30-minute duration should not be reported separately.

Prolonged services in the inpatient setting involving direct (face-to-face) patient contact that is beyond the usual service are considered for reimbursement on the same day as an initial hospital visit (1-99221, 1-99222, 1-99223, 3-99251, 3-99252, 3-99253, 3-99254, and 3-99255) or a subsequent hospital visit (1-99231, 1-99232, 1-99233, 3-99251, 3-99252, 3-99253, 3-99254, and 3-99255).

- Procedure code 1-99356 should be used to report the first hour of prolonged service and will be limited to one per day.
- Procedure code 1-99357 should be used to report each additional 30 minutes and will be limited to a quantity of three units or one-and-one-half hours per day.
- Prolonged physician services will not be reimbursed in addition to critical care and/or emergency room visits billed on the same day.

Prolonged physician services and physician standby services without face-to-face contact (1-99358, 1-99359, and 1-99360), are not a benefit of the Texas Medicaid Program.

Consultation Services

A consultation (3-99241, 3-99242, 3-99243, 3-99244, 3-99245, 3-99251, 3-99252, 3-99253, 3-99254, and 3-99255) is an evaluation and management service provided at the request of another provider for the evaluation of a specific condition or illness. A consultation must consist of the following in order to be billed as such:

- There must be a request from the referring provider for the evaluation of a particular condition or illness.
- There must be correspondence from the consulting provider back to the referring provider indicating his medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary. If treatment is initiated and the patient returns for follow up care, an established patient visit should be billed. If the purpose of the referral is to transfer care, a consultation may not be billed.

The medical records, maintained by both the referring and consulting providers, must identify their counterpart and reason for consultation.

Inpatient Services

Hospital visits, observation, and discharge (1-99221, 1-99222, 1-99223, 1-99231, 1-99232, 1-99233, 1-99234, 12-99235, 1-99236, 1-99238, and 1-99239) are limited to one per day for the same provider.

Concurrent care exists when services are provided to a patient by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the patient in accordance with accepted standards of good medical practice.

Concurrent care will not be paid to providers of the same specialty for the same or related diagnoses. Diagnoses will be considered related when there is a three-digit match of the primary Internal Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) diagnosis code.

Denied concurrent care will be considered on an appeal basis when accompanied by documentation of medical necessity. Concurrent care will be considered for reimbursement to providers of different specialties when services are provided for unrelated diagnoses involving different organ systems.

If a hospital admission (1-99221, 1-99222, and 1-99223) and physician observation visit (1-99217, 1-99218, 1-99219, 1-99220, 1-99234, 1-99235, and 1-99236) are billed the same day by the same provider, the hospital admission will be paid, and the physician observation visit will be denied.

If an initial hospital visit (1-99221, 1-99222, and 1-99223) following admission is billed on the same day by the same provider as an emergency department visit (1-99281, 1-99282, 1-99283, 1-99284, and 1-99285), inpatient consultation (3-99251, 3-99252, 3-99253, 3-99254, and 3-99255), office visit (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215), or outpatient consultation (3-99241, 3-99242, 3-99243, 3-99244, and 3-99245), the initial hospital visit will be paid, and the other visits will be denied.

If a subsequent hospital visit (1-99231, 1-99232, and 1-99233) following admission is billed on the same day by the same provider as an emergency department visit (1-99281, 1-99282, 1-99283, 1-99284, and 1-99285), an office visit (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, and 1-99215), or an outpatient consultation (3-99241, 3-99242, 3-99243, 3-99244, and 3-99245), the subsequent hospital visit will be paid, and the other visits will be denied.

Only one initial hospital care visit may be paid to the same provider within a 30-day period regardless of diagnosis. Subsequent care visits may be considered for reimbursement during this time period. A subsequent hospital visit (1-99231, 1-99232, and 1-99233) may be reimbursed on the same day to the same provider when critical care services (1-99291 and 1-99292) are billed.

Evaluation and management services provided in a hospital setting following a major procedure, provided by the same provider and/or in direct follow-up for post-surgical care, are included in the surgeon's global surgical fee and will be denied as included in another procedure.

A physician who did not perform the surgery and provides postoperative surgical care in the time frame that is included in the global surgical fee must bill with modifier 55. This may only be done when the surgeon submits a charge for surgical care only and there was an agreement between the physicians to split the care of the patient.

Discharge

Discharge management (1-99238 and 1-99239) billed on the same date of service as the admission by the same provider will be denied.

Discharge management (1-99238 and 1-99239) billed on the same date of service as an emergency room visit by the same provider will be denied, but may be considered for reimbursement upon appeal, if the services were provided at a separate time.

Only one discharge management service will be considered for reimbursement per day.

Subsequent hospital visits billed on the same day as discharge management, by the same provider, will be denied.

Initial and or subsequent hospital visit codes (1-99221, 1-99222, 1-99223, 1-99231, 1-99232, and 1-99233) billed on the same day as hospital discharge day management (1-99238 and 1-99239) is denied as part of another procedure billed on the same day.

Nursing Facility Services

Initial nursing facility assessments (1-99304, 1-99305, and 1-99306), subsequent nursing facility care (1-99307, 1-99308, 1-99309, and 1-99310), and annual nursing facility assessments (1-99318) are a benefit of the Texas Medicaid Program when billed for services rendered in a nursing facility. Initial nursing facility assessments (1-99304, 1-99305, and 1-99306) include all services related to an admission to the nursing facility.

All evaluation and management services, irrespective of the place of service, provided in conjunction with the admission by the same provider, are considered part of the initial nursing facility care when performed on the same day as the admission.

Comprehensive initial nursing facility assessments (1-99304, 1-99305, and 1-99306) are limited to one every six months.

Initial nursing facility assessments (1-99304, 1-99305, and 1-99306), subsequent nursing facility care (1-99307, 1-99308, 1-99309, and 1-99310), or nursing facility discharge day management (1-99315 and 1-99316) billed on the same day as initial hospital care (1-99221, 1-99222, and 1-99223) by the same provider will be denied as part of another procedure.

Subsequent nursing facility care evaluation and management procedure codes (1-99307, 1-99308, 1-99309, and 1-99310) are limited to one per day regardless of diagnosis.

Domiciliary, Rest Home, or Custodial Care

Domiciliary and rest home care procedure codes, used to report evaluation and management services in a facility which provides room, board, and other personal assistance services, may be considered for reimbursement when billed using procedure codes 1-99324, 1-99325, 1-99326, 1-99327, 1-99328, 1-99334, 1-99335, 1-99336, and 1-99337 for new and established patient visits.

Established patient visits billed on the same day as a new patient visit, by the same provider, will be denied as part of another procedure. Established patient visits are limited to one per day regardless of diagnosis.

Home Services

Home services, services that are provided in a private residence, will be considered for reimbursement when billed with procedure codes 1-99341, 1-99342, 1-99343, 1-99344, 1-99345, 1-99347, 1-99348, 1-99349, or 1-99350. New patient visits will be limited to once every three years.

A subsequent home visit (1-99347, 1-99348, 1-99349, and 1-99350) billed on the same day as a new patient home visit (1-99344 and 1-99345) by the same provider will be denied as part of another procedure billed on the same day, regardless of the diagnosis.

Subsequent home evaluation and management codes are limited to one per day regardless of diagnosis.

For more information, call the TMHP Contact Center at 1-800-925-9126.