5160-4-06 **Specific provisions for evaluation and management (E&M) services.**

(A) Site-related provisions. Policies concerning payment for evaluation and management (E&M) services may depend on the site in which the services are provided.

(1) Ambulance. Policies for E&M services provided during ambulance transport by hospital staff members are set forth in rule 5160-2-04 of the Administrative Code. Payment for E&M services provided during ambulance transport by practitioners who are not hospital staff members is subject to the following conditions:

(a) Such services require direct face-to-face contact between a practitioner and the individual being transported, which begins when the practitioner assumes responsibility for the care of the individual at the point of pickup and ends when the receiving facility assumes this responsibility. Remote direction of emergency care en route (e.g., communication by radio with a physician located in a hospital) is not direct face-to-face contact.

(b) Routine monitoring and maintenance (e.g., the recording of vital information, pulse oximetry, the initiation of mechanical ventilation) is included; no separate payment is made.

(c) Services provided by other members of the transport team (the ambulance crew) cannot be reported by the practitioner as E&M services.

(2) Nursing facility (NF). Policies are set forth in Chapter 5160-3 of the Administrative Code. The periodic review of a NF resident's medical record, plan of care, or habilitation plan is part of overall medical direction, payment for which is made to the NF rather than to the practitioner.

(3) Federally qualified health center, outpatient health facility, or rural health clinic. Policies are set forth in Chapter 5160-28 of the Administrative Code. Specific claim format requirements may apply.

(B) Service-related provisions.

(1) After-hours care. Additional payment may be made for E&M services provided in an office or clinic setting after regularly scheduled business hours.

(2) Bundled services. No separate payment is made for E&M services provided in conjunction with certain covered diagnostic or therapeutic procedures, which are identified in other rules in Chapter 5160-4 of the Administrative Code.

(3) Consultation. Payment may be made for a consultation provided by a licensed medical practitioner regarding the evaluation and management of a specific medical problem.

(a) The person who requests the consultation must be a licensed medical practitioner enrolled as a medicaid provider. For purposes of this rule, a medical visit initiated by someone other than a licensed medical practitioner (e.g., a patient, a family member, a teacher, a social worker) is not a consultation.

(b) The request for a consultation, the need for a consultation, the consultant's opinion, and any services that were ordered or performed in relation to the consultation must be documented in the patient's medical record.

(c) Follow-up visits initiated by a consultant for the purpose of evaluation and management of a patient's condition are E&M services rather than consultation.

(d) The referring practitioner must be identified on any claim for consultation that is submitted.

(4) Critical-care services. Payment for covered critical-care services provided by a single practitioner is limited to two hours per patient per day. This time limit does not apply to critical-care services rendered during the transportation of a critically ill or injured individual older than twenty-four months.

(5) Hospital observation services (including admission and discharge services). Payment may be made for not more than twenty-two hours of medical observation of an individual who is treated in a hospital but does not require inpatient hospital admission.

(a) Emergency department services are not observation.

(b) If during observation the individual is admitted to the hospital as an inpatient, payment for the observation services depends on the role of the practitioner.

(i) If the observing practitioner continues as the individual's attending practitioner after admission, the observation services are treated as inpatient E&M services and must be reported as such on any claim submitted.

(ii) If the observing practitioner does not continue as the individual's attending practitioner after admission, the observation services are not reported as inpatient E&M services.

(6) Inpatient hospital visits following surgery. No separate payment is made for an E&M service provided within the postoperative period for a covered surgical procedure. The postoperative period, which is listed in appendix DD to rule 5160-1-60 of the Administrative Code, includes the day of surgery. The postoperative period for one surgical procedure may be extended by the performance soon afterward of another surgical procedure.

(7) Medication-assisted treatment. Separate payment may be made for the provision of self-administered take-home medication, in addition to an E&M service, if the following conditions are met;

(a) The rendering provider is a physician, physician assistant, certified nurse practitioner, or clinical nurse specialist who participates in an opioid treatment program (OTP) in accordance with 42 C.F.R 8.1 (as in effect on October 1, 2017) ;

(b) The medication is a pharmaceutical prescribed for the treatment of opioid addiction.

(c) The provider must include in the patient's medical record documentation that supports the amount of the take home doses administered.

(C) Limitations.

(1) Payment for an E&M service that is not medically necessary in accordance with rule 5160-1-01 of the Administrative Code is subject to recovery.

(2) Concurrent care is the provision of service to one individual on one date of service by more than one practitioner in the same group practice. When concurrent care is provided, payment may be made only for one E&M service (i.e., the separate services are treated as though they were provided by the same practitioner for the same purpose) unless one of the following conditions applies:

(a) The services were provided for unrelated purposes;

(b) The practitioners had different specialties; or

(c) Each practitioner supplied knowledge or skill the other practitioners could not provide.

(3) E&M services in excess of twenty-four during a calendar year that are provided to an individual in an outpatient setting or a NF are subject to post-payment review. The following services are excluded from the calculation of the number of E&M services provided during a calendar year:

(a) Pregnancy-related services, which are described in rule 5160-21-04 of the Administrative Code;

(b) Early and periodic screening, diagnostic, and treatment (EPSDT) services;

(c) Inpatient hospital visits;

(d) Critical-care visits;

(e) An allergen immunotherapy service that is not provided in conjunction with an E&M service; and

(f) An E&M service provided for any of the following conditions or purposes:

(i) End-stage renal disease;

(ii) Chemotherapy or radiation therapy for malignancy;

(iii) End-stage lung disease;

(iv) Unstable diabetes or diabetes with complications;

(v) Uncontrolled hypertension or hypertension with complications;

(vi) Neoplasms or leukemia;

(vii) Organ transplantation;

(viii) Hereditary anemias;

(ix) Hemophilia or other congenital disorders of clotting factors;

(x) Acquired hemolytic anemias;

(xi) Aplastic anemias;

(xii) Deficiency of humoral immunity;

(xiii) Deficiency of cell-mediated immunity;

(xiv) Combined immunity deficiency;

(xv) Cystic fibrosis;

(xvi) Malabsorption;

(xvii) Failure to thrive;

(xviii) Infant prematurity;

(xix) Respiratory distress syndrome or other respiratory conditions of the fetus or newborn; or

(xx) The terminal stage of any life-threatening illness.

Effective:

Five Year Review (FYR) Dates: 6/1/2022

Certification

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