

Same Day, Same Service Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

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Application

This reimbursement policy applies to all Medicare Advantage products and for services reported using the 1500 Health Insurance Claim Form (a/k/a CMS 1500) or its electronic equivalent or its successor form. This policy applies to all physicians and other qualified health care professionals.

Policy

Overview

The Same Day/Same Service Policy addresses those instances when a single code should be reported by a physician(s) or other qualified health care professional(s) for Evaluation and Management (E/M) services for a patient on a single date of service. Generally, a single E/M code should be used to report all services provided for a patient on each given day.

For the purpose of this policy, the Same Specialty Physician or Other Qualified Health Care Professional is defined as a physician and/or other qualified health care professional of the same group and same specialty reporting the same Federal Tax Identification number.

Reimbursement Guidelines

The CMS Claims Processing Manual states:

"Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

...
When a hospital inpatient or office/outpatient evaluation and management service (E/M) are furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care both the critical Care Services (CPT codes 99291 and 99292) and the previous E/M service may be paid on the same date of service. Hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient.

During critical care management of a patient those services that do not meet the level of critical care shall be reported using an inpatient hospital care service with CPT Subsequent Hospital inpatient or observation Care using a code from CPT code range 99231-99233.

Both Initial Hospital inpatient or observation Care (CPT codes 99221-99223) and Subsequent Hospital inpatient or observation Care codes are "per diem" services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

Physicians and qualified nonphysician practitioners (NPPs) are advised to retain documentation for discretionary contractor review should claims be questioned for both hospital care and critical care claims. The retained documentation shall support claims for critical care when the same physician or physicians of the same specialty in a group practice report critical care services for the same patient on the same calendar date as other E/M services."

UnitedHealthcare Medicare Advantage will pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit descriptors contain the phrase "per day" which means that the code and the payment established for the code represent all services provided on that date. The physician should select a code that reflects all services provided during the date of the service.

In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, UnitedHealthcare Medicare Advantage will NOT reimburse physician B for the second visit. If the physicians are each responsible for a different

aspect of the patients care and are different specialties and are billed with different diagnoses, UnitedHealthcare Medicare Advantage will reimburse for both visits.

UnitedHealthcare Medicare Advantage will not pay a physician for an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician.

The National Correct Coding Initiative Policy Manual states:

"Procedures shall be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code.

A physician shall not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services."

According to correct coding methodology, physicians are to select the code that accurately identifies the service(s) performed. Multiple E/M services, when reported on the same date for the same patient by the same specialty physician, will be subject to edits used by and sourced to third party authorities. As stated above, physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Significant, Separately Identifiable Evaluation and Management Service

According to the CPT® book "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service)..."

UnitedHealthcare Medicare Advantage will allow modifier 25 to indicate a significant and separately identifiable E/M service when a second physician in the same group and specialty provides a separate E/M service on the same day for an unrelated problem. However, there are instances when modifier 25 would not be appropriate to report, including but not limited to, reporting two E/M services where one is a "per day" code or reporting separate services when a more comprehensive code exists that describes the services.

Definitions

Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number.
Same Specialty Physician or Other Qualified Health Care Professional	Physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

Questions and Answers

1	Q: If a patient is seen in the office at 3:00 p.m. and admitted to the hospital at 1:00 a.m. the next day, may both the office visit and the initial hospital care be reported?
	A: Yes. Because different dates are involved, both codes may be reported. The CPT states services on the same date must be rolled up into the initial hospital inpatient or observation care code. The term "same date" does not mean a 24 hour period. Refer to the CPT book for more information.

2	<p>Q: May a physician report both a hospital visit and hospital discharge day management service on the same day?</p> <p>A: No. The hospital visit descriptors include the phrase "per day" meaning they include all care for a day. Codes 99238-99239 (hospital discharge day management services) are used to report services on the final day of the hospital stay. To report both the hospital visit code and the hospital discharge day management services code would be duplicative.</p>
3	<p>Q: If a patient is admitted as an inpatient and discharged on the same day, may the hospital discharge day management code be reported?</p> <p>A: No. To report services for a patient who is admitted as an inpatient and discharged on the same day, use only the appropriate code for Observation or Inpatient Care Services (Including Admission and Discharge Services) as described by CPT codes 99234-99236.</p>
4	<p>Q: May a physician or separate physicians of the same group and specialty report multiple hospital visits on the same day for the same patient for unrelated problems?</p> <p>A: No. The inpatient hospital visit descriptors contain the phrase "per day" which means that the code and the payment established for the code represent all services provided on that date. The physician/s should select a single code that reflects all services provided during the date of the service.</p>
5	<p>Q: In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, will UnitedHealthcare Medicare Advantage pay physician B for the second visit?</p> <p>A: No. The inpatient hospital visit descriptors contain the phrase "per day" which means that the code and the payment established for the code represent all services provided on that date. The physician/s should select a single code that reflects all services provided during the date of the service.</p>
6	<p>Q: If a physician sees his patient in the emergency room and decides to admit the person to the hospital, should both services (the emergency department visit and the initial hospital visit) be reported?</p> <p>A: No. When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.</p>
7	<p>Q: If a patient is seen for more than one E/M or other medical service on a single date of service, and each service is performed by a physician with a different specialty designation, but in the same group practice, would each E/M or other medical service be separately reimbursable?</p> <p>A: Yes, in certain circumstances. An E/M or other medical service provided on the same date by different physicians who are in a group practice but who have different specialty designations may be separately reimbursable. The Same Day/Same Service policy applies when multiple E/M or other medical services are reported by physicians in the same group and specialty on the same date of service. In that case, only one E/M is separately reimbursable, unless the second service is for an unrelated problem and reported with modifier 25. This would not apply when one of the E/M services is a "per day" code.</p>
8	<p>Q: If a patient is seen for more than one E/M or other medical service on a single date of service, and each service is performed by a physician of the same group and specialty but with a different subspecialty designation, would each E/M or other medical service be separately reimbursable?</p> <p>A: No. Subspecialty is not considered when applying reimbursement policy.</p>

Resources

www.cms.gov

American Medical Association (AMA) Current Procedural Terminology (CPT®)

Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners Sections: 30.6.5, 30.6.7, 30.6.8, 30.6.9, 30.6.9.1, 30.6.12

History	
4/1/2023	Policy Version Change History Section: Entries prior to 4/1/2021 archived
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4/1/2021	Policy Version Change Updated Template History Section: Entries prior to 4/5/2019 archived
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