Same Day/Same Service Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

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 reimbursement policies may 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 and, when specified, to those billed on UB04 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 reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare 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 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, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to 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 products and all network and non-network physicians and Other Qualified Healthcare Professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and Other Qualified Healthcare Professionals.

United Healthcare Commercial
This Reimbursement Policy applies to all UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange
This Reimbursement Policy applies to all Individual Exchange benefit plans.

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 Healthcare Professional (s) for multiple 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 E/M services provided for a patient on each given day. Prolonged services and care plan oversight may be exceptions. (See UnitedHealthcare's Prolonged Services and Care Plan Oversight policies for more information.)

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Reimbursement Guidelines

The Medicare 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.
…
Contractors 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, contractors do not pay physician B for the second visit. The hospital visit descriptors include the phrase “per day” meaning care for the day.
If the physicians are each responsible for a different aspect of the patient’s care, pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses.”

The National Correct Coding Initiative Policy Manual states:
"Procedures should 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 should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services."

Consistent with Medicare, UnitedHealthcare's Same Day/Same Service policy recognizes physicians or Other Qualified Healthcare Professionals of the same group and specialty as the same physician; physician subspecialty is not considered. 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 or Other Qualified Health Care Professional, 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.

Edit Sources

UnitedHealthcare sources its Same Day Same Service edits to methodologies used and recognized by third party authorities. Those methodologies can be definitive or interpretive. A definitive source is one that is based on very specific instructions from the given source. An interpreted source is one that is based on an interpretation of instructions from the identified source. Please see the edit types section below for further explanations of these sources. The sources used to determine if a Same Day Same Service edit is appropriate are as follows:

Current Procedural Terminology book *(CPT®)* from the American Medical Association (AMA);
CMS National Correct Coding Initiative (CCI) edits;
CMS Policy; and
Physician specialty societies (e.g., American Academy of Orthopedic Surgeons (AAOS), American Congress of Obstetricians and Gynecologists (ACOG), American College of Cardiology, and Society of Cardiovascular Interventional Radiology).

Please refer to the Claim Estimator tool to review appropriate bundling of services under UnitedHealthcare

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reimbursement policies. The Claim Estimator tool can be found at the UnitedHealthcare website at: unitedhealthcareonline.com

Edit Types

The following are edit types that may be applied for E/M services in the Same Day Same Service Policy.

CCI Definitive: An edit sourced to specific billing guidelines from the General Correct Coding Policies contained in the National Correct Coding Policy Manual published by CMS. For example, the Evaluation and Management Services section (chapter xi) specifically states "A physician should not report an 'initial' per diem E&M service with the same type of 'subsequent' per diem service on the same date of service." UnitedHealthcare will not separately reimburse for an initial and a subsequent per diem service on the same date, such as 99223 and 99232.

CMS Definitive: The CMS Program Memorandum (cms.hhs.gov), Transmittal No. AB-02-158, Nov. 8, 2002, gives clarification of billing requirements for code G0247. It states: “G0247 must be submitted on the same claim with the same date of service as either G0245 or G0246 in order to be considered for payment”; therefore, the codes G0245 and G0246 are listed as principal procedures for code G0247.

CPT Definitive: Based on the current CPT® Professional Edition code 53500 is for “Ureterolysis, transvaginal, secondary, open, including cystourethroscopy (for example, postsurgical obstruction, scarring). Below the code description is the following statement, “Do not report 53500 in conjunction with 52000.” This statement gives a very specific directive that 53500 cannot be used with 52000.

Interpretation of NCCI: The National Correct Coding Initiative (NCCI) has edits to pay the carpal tunnel neuroplasty code 64721 and deny cast code 29075 and splinting code 29125. The NCCI does not contain like edits for cast code 29085 and splinting code 29105 with carpal tunnel neuroplasty code, 64721. Since the NCCI does have edits including these casting and splinting codes that could be reported with 64721, they are sourced to an Interpretation of NCCI.

Interpretation of CMS: CMS (http://cms.hhs.gov/) utilizes newsletters with general guidelines to give direction for certain issues. General coding and billing guidelines are outlined but often do not contain reference to specific CPT or HCPCS codes. In these instances, an interpretation is made to create edits to accommodate these directives. For example, in a CMS Newsletter #1010, June 12, 1998, and also in the 1999 Physician Fee Schedule, surgical tray code A4550 is considered a bundled code and not separately billable. CMS states: “HCFA has identified a number of supplies, such as surgical trays (A4550) that have been paid separately from the fee schedule. The new practice expense RVUs would incorporate these supplies in their values. Thus, separate payment no longer would be made for these items. Code A4550 also has a status indicator of ‘B’ meaning “bundled code.” Code A4550 has been added as an edit (deny) to other surgical procedures.

Interpretation of CPT: CPT guidelines under Endovascular Repair of Descending Thoracic Aorta state that codes 33880-33891 include all balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment and are not reported separately. A determination is made as to what angioplasty or stent deployment codes fall within the treatment zone of 33880-33891.

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 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.

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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 Specialty Physician or Other Qualified Health Care Professional	Physicians and/or Other Qualified Healthcare Professionals of the same group and same specialty reporting the same federal Tax Identification Number. For qualified health care professionals United may, at times, identify same specialty by related Taxonomy Codes.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services, reporting the same National Provider Identifier (NPI).
Taxonomy Code	A Taxonomy Code is a unique 10-character code that designates your classification and specialization. To find the Taxonomy Code that most closely describes your provider type, classification, or specialization, use the National Uniform Claim Committee (NUCC) code set list.

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 care code. The term "same date" does not mean a 24-hour period. Refer to the CPT book for more information.
2	**Q:** May a physician report both a hospital visit and hospital discharge day management service on the same day? **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.
3	**Q:** If a patient is admitted as an inpatient and discharged on the same day, may the hospital discharge day management code be reported? **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.
4	**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? **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.
5	**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 pay physician B for the second visit? **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 physicians should select a single code that reflects all services provided during the date of the service.
6	**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?

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	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.
7	**Q:** If a patient is seen for more than one E/M 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 service be separately reimbursable? **A:** Yes, in certain circumstances. An E/M 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 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.
8	**Q:** If a patient is seen for more than one E/M 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 service be separately reimbursable? **A:** No. Subspecialty is not considered when applying this reimbursement policy.
9	**Q:** If a physician and a Qualified Healthcare Professional from the same group with the same specialty (as identified by their related Taxonomy Codes) both provided per day E/M services to the same patient on a single date of service, would each E/M service be separately reimbursable? **A:** No. Same specialty under the same group practice allows only one E/M service to be eligible for reimbursement. The physician and Qualified Healthcare Professional should select a single code reflecting all services provided during the service date.
10	**Q:** If a patient is seen for more than one per day E/M service on a single date of service, and each service is performed by the Same Individual Physician or Other Qualified Healthcare Professional, would each E/M be separately reimbursable? **A:** No. The inpatient hospital E/M code descriptions contain the phrase "per day" which means that the code and the payment established for the code represent all services provided on that date by the Same Individual Physician or Other Qualified Healthcare Professional. The physician or Other Qualified Healthcare Professional should select a single code reflecting all services provided during the service date.

Resources

American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications

History

4/1/2026	Anniversary review and version change History Section: Entries prior to 4/1/2024 archived
5/25/2025	Anniversary review and version change History section: Entries prior to 5/25/2023 archived
8/26/2024	Policy Version Change Overview section updated Edit Types section updated Definitions updated

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	Questions and Answers section updated Added Q&A #9 and 10
10/8/2003	Policy implemented by UnitedHealthcare Employer & Individual
4/10/2002	Policy approved by the Clinical Review Committee

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