

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1545	Date: JUNE 27, 2008
	Change Request 5792

Transmittal 1473, sent to you on March 7, 2008, is being rescinded and replaced with transmittal 1545. An error occurred in the manual portion of the instruction in Section A. The words "emergency department" has been deleted. In addition, a portion of the Summary of Changes has been added for clarification. All other information in this revision remains the same.

SUBJECT: Payment for Inpatient Hospital Visits (Codes 99221 - 99239)

I. SUMMARY OF CHANGES: This transmittal correctly states longstanding payment policy in Section A that 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. When a hospital inpatient evaluation and management service (E/M) was 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.

Physicians and qualified nonphysician practitioners are advised to retain supporting documentation for discretionary contractor review should claims be questioned. Appropriate coding was discussed. Inpatient hospital care codes are "per diem" codes.

New / Revised Material

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	Chapter / Section / Subsection / Title
R	12/30/30.6.9/Payment for Inpatient Hospital Visits (Codes 99221 - 99239)

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is

not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1545	Date: June 27, 2008	Change Request: 5792
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SUBJECT: Payment for Inpatient Hospital Visits – General (Codes 99221 – 99239)

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: This transmittal updates Chapter 12, §30.6.9 in regard to billing inpatient hospital visits provided on the same day as critical care services. This transmittal also correctly states longstanding payment policy in section A that 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.

B. Policy: When critical care services are provided to a patient on the same calendar date where a hospital inpatient evaluation and management (E/M) service was furnished and at which time the patient did not require critical care services, both the critical care and inpatient hospital care service may be paid. 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 visit codes (99231 – 99233). Both initial inpatient hospital care codes and subsequent hospital 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. 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.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5792.1	Contractor shall instruct physicians and qualified NPPs they may bill both critical care services and inpatient hospital care services for the same patient on the same calendar date when the patient did not require critical care during the previous encounter to receiving critical care services.	X			X						
5792.2	Contractor shall instruct physicians and qualified NPPs they may bill both critical care services and	X			X						

Number	Requirement	A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	inpatient hospital care services for the same patient on the same calendar date when during critical care management the services do not meet the level of critical care services.										
5792.2.1	For the scenario identified in 5792.2 contractors shall instruct physicians and qualified NPPs they may bill inpatient hospital care services when during critical care management the level of care does not meet critical care.	X			X						
5792.2.2	For the scenario identified in 5792.2.1 contractor shall instruct physicians and qualified NPPs to report subsequent hospital care services (CPT codes 99231 – 99233).	X			X						
5792.2.3	Contractors shall instruct physicians and qualified NPPs that both initial inpatient hospital care codes and subsequent hospital care codes are “per diem” services and may be reported only once per day.	X			X						
5792.3	Contractors shall instruct physicians and qualified NPPs they shall not be paid for hospital emergency department services when they provide critical care services to the same patient on the same date of service.	X			X						
5792.4	Contractors shall instruct physicians and qualified NPPs to retain documentation for discretionary contractor review 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 and the claims are questioned.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5792.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to	X			X						

Number	Requirement	A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5792.3	This is longstanding payment policy established at the beginning of the physician fee schedule.

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Kit Scally (Cathleen.Scally@cms.hhs.gov)

Post-Implementation Contact(s): Appropriate Regional Office staff

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers and Regional Home Health Carriers (RHHs)*, use following statement:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*, use the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30.6.9 - Payment for Inpatient Hospital Visits (Codes 99221 - 99239)

(Rev. 1545; Issued: 06-27-08; Effective Date: 04-01-08; Implementation Date: 04-07-08)

A. Hospital Visit and Critical Care on Same Day

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 Care using a code from CPT code range 99231 – 99233.

Both Initial Hospital Care (CPT codes 99221 – 99223) and Subsequent Hospital 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.

B. Two Hospital Visits Same Day

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.

C. Hospital Visits Same Day But by Different Physicians

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, carriers 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. There are circumstances where concurrent care may be billed by physicians of the same specialty.

D. Visits to Patients in Swing Beds

If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply.