Clover

Clover Health Same Day Same Service Reimbursement Policy

Policy # RP-048

Policy Title	Same Day Same Service Reimbursement Policy
Policy Department	Payment Strategy & Optimization
Effective Date	4/1/2022
Revision Date(s)	
Next Review Date	

Disclaimer:

Clover Health applies The Center for Medicare and Medicaid Services (CMS) criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

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 medical and/or 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 Healthcare 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.

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.

Policy:

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.

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.

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."

Clover Health 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, Clover Health will NOT reimburse physician B for the second visit. If the physicians are each responsible for a different aspect of the patient's care and are different specialties and are billed with different diagnoses, Clover Health will reimburse for both visits.

Clover Health 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)."

Clover Health 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.

References
http://www.cms.gov/
CMS Claims processing Manual
Current Procedural Terminology (CPT®) and associated publications and services