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 and, when specified, to those billed on UB04 forms (CMS 1450). 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 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 healthcare 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 healthcare 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. Services requiring prior authorization can be found at UnitedHealthcareOnline.com > Notifications/Prior Authorizations.

*CPT® is a registered trademark of the American Medical Association.

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

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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 health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Payment Policies for Employer & Individual and for Community and State please use this link. Employer & Individual are listed under Reimbursement Policies-Commercial. Community and State are listed under UnitedHealthcare Community Plan Reimbursement Policies.

Policy

Overview

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." 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.

Medicare requires that Current Procedural Terminology (CPT) modifier 25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Carriers pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnosis are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 is added to the E/M code on the claim.

Reimbursement Guidelines

UHC will not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office or outpatient setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

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
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 non-physician 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.

UHC 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, UHC will NOT reimburse physician B for the second visit. If the physicians are each responsible for a different unrelated diagnosis and are different specialties, UHC will reimburse for both visits.

UHC will not permit the use of CPT modifier “25” to generate payment for multiple evaluation and management services on the same day by the same physician, notwithstanding the CPT definition of the modifier.

UHC 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.
UnitedHealthcare Medicare Advantage
Reimbursement Policy
CMS 1500

CMS Benefit Policy Manual
Chapter 15-Covered Medical and Other Health Services

CMS Claims Processing Manual
Chapter 12 Physicians and Non-Physician Practitioners

Chapter 26 Completing and Processing Form CMS-1500 Data Set

UnitedHealthcare Medicare Advantage Coverage Summaries

Evaluation and Management Services

MLN Matters
Article MM4032, Payment for Office/Outpatient E/M Visits (Codes 99201-99215)

Others
CMS Medicare Quarterly Provider Compliance Newsletter-Guidance to Address Billing Errors, Volume 1, Issue 2, February 2011, CMS Website

How to Use the Medicare National Correct Coding Initiative (NCCI) Tools, ICN 901346 April 2015, CMS Website

National Correct Coding Initiative Edits, CMS Website

History

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<tr>
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<tr>
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