

## Inpatient and Nursing Facility Billing by a Second Physician

Effective January 1, 2010 CMS eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation G-codes. Subsequently NAS has received multiple questions on appropriate coding for inpatient hospital and nursing home services. In particular, the coding is in question when such services are performed by a physician other than the admitting physician of record and when the services provided do not meet the criteria for the lowest level of the hospital care or nursing facility admitting codes.

*“In the inpatient hospital setting and the nursing facility setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306).”*

Typically, an evaluation and management (E/M) service must reflect at least the minimum requirements of the lowest level of code in a code family in order to be paid. Providers are instructed to select the highest level service within a Category or Subcategory of E/M codes for which all criteria are met. If all of the criteria for a code are not met, then a lower level code must be selected.

The following billing rules apply to the second and subsequent physicians:

1. Where an inpatient hospital service performed by a physician other than the admitting physician of record is necessary, with all required components performed and appropriately documented, then that level of service (99221, 99222, 99223) is appropriate for billing by and payment to the second or subsequent physicians.
2. If criteria for even 99221 “Initial Hospital Care” are not met by the second or subsequent physicians, but a service was necessary and all of the required components performed and appropriately documented meet criteria for “Subsequent Hospital Care”, then that level of service (99231, 99232 or 99233) is appropriate for billing and payment.
3. Where a nursing home service performed by a physician other than the admitting physician of record is necessary, with all required components performed and appropriately documented, then that level of service (99304-

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99306) is appropriate for billing by and payment to the second or subsequent physicians.

4. If criteria for even a 99304 "Initial Nursing Facility Care" are not met by the second or subsequent physicians,, but a service was necessary and all of the required components performed and appropriately documented meet criteria for a "Subsequent Nursing Facility Care", then that level of service (99307, 99308, 99309 or 99310) is appropriate for billing and payment.
5. If, in what should be a very **rare** circumstance, an E/M service is necessary, performed and documented that does not meet even the criteria for a 99231 or 99304, then a 99499 may be paid (which requires individual adjudication and pricing based on the submitted documentation).

In what should be a rare circumstance where the provider concludes only 99499 is appropriate, it is the responsibility of the provider to ensure all necessary information has been documented in the medical record. The service must meet medical necessity and reasonableness standards. Documentation must include the place of service and a brief statement why another E/M code does not apply.

A concise description of the type of service is required in Item 19 on the CMS-1500 paper claim form or the electronic equivalent. Examples of descriptions include: "office/other outpatient visit", "office/outpatient consult", "hospital inpatient consultation", "hospital admission", etc.

**DO NOT send documentation with the claim.** NAS will send a letter requesting documentation for the unlisted E/M service after the claim has been received.

### **CMS transmittal 1875 dated December 14, 2009 states:**

Effective January 1, 2010, the consultation codes are no longer recognized for Medicare part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. In the inpatient hospital setting and the nursing facility setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306). The principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier "-AI",

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Principal Physician of Record, in addition to the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.

In the CAH setting, those CAHs that use method II shall bill the appropriate new or established visit code for those physician and non-physician practitioners who have reassigned their billing rights, depending on the relationship status between the physician and patient.

In the office or other outpatient setting where an evaluation is performed, physicians and qualified nonphysician practitioners shall use the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician. All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services. These rules are applicable for Medicare secondary payer claims as well as for claims in which Medicare is the primary payer.

Payment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record. Physicians and qualified NPPs shall report initial nursing facility care codes for their first visit with the patient. The principal physician of record must append the modifier “-AI” Principal Physician of Record, to the initial nursing facility care code when billed to identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. Follow-up visits shall be billed subsequent nursing facility care visits.

**Effective Date: January 4, 2010**

**Implementation Date: January 4, 2010**

**Sources: Internet Only Manual *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6 and 30.61; Transmittal 1875, dated December 14, 2009**