5101:3-4-06 **Physician visits.**

(A) Definitions pertaining to physician visits.

(1) A "physician visit" or an "evaluation and management (E & M) service" is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient except for code 99211, which does not require the presence of a physician.

(2) "Outpatient visits" are visits provided to a patient in a physician's office, a physician's group practice office, a patient's home (excluding long-term care facilities), hospital emergency room, outpatient hospital, or clinic.

(3) "Inpatient visits" are visits provided to a hospital inpatient as defined in rule 5101:3-2-02 of the Administrative Code or visits provided to a patient in a long-term care facility (LTCF).

(4) The following terms are defined in the current procedural terminology (CPT):

(a) New and established patient;

(b) Concurrent care;

(c) Counseling;

(d) Levels of E & M services;

(e) Presenting problem; and

(f) Intra service, face-to-face and unit/floor time.

(B) Providers must select and bill the appropriate visit code. ~~:~~ Visits in conjunction with diagnostic or therapeutic codes are billable in accordance with the provisions set forth in rule Chapter 5101:3-4 of the Administrative Code.

(C) Office or other outpatient services.

(1) For the reimbursement of physician services provided to a patient in a physician's office, a professional medical group office, a fee-for-service clinic, or an outpatient hospital, the provider must bill the appropriate code listed in the CPT as office or other outpatient services.

(2) For reimbursement of visits provided to a patient in a rural health clinic, an outpatient health facility or a federally qualified health center, the provider must itemize the appropriate covered code listed under office or other outpatient services in conjunction with the appropriate encounter code for the service and provider type.

(3) After hours care.

(a) The department will compensate providers of physician services for visits provided after regularly scheduled office hours when the services are provided in an office or clinic setting.

(b) Reimbursement for after hours care is in addition to the basic services provided to the patient. For reimbursement, providers should bill the appropriate covered code listed in appendix DD to rule 5101:3-1-60 of the Administrative Code in addition to the surgical and/or visit codes.

(D) Hospital inpatient services.

(1) For the reimbursement of visits provided to hospital inpatients, the provider must bill the appropriate code listed in the CPT under hospital inpatient services in accordance with the instructions and definitions in the CPT.

(2) Hospital care to newborns should be billed in accordance with paragraph (N) of this rule.

(E) Consultations.

(1) A consultation is a type of service provided by a physician whose opinion or advice regarding the evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The person requesting the consultation must be a health care professional who is eligible to bill the department for physician services. When a teacher, social worker, or other non-physician (excluding a physician assistant or an advanced practice nurse) requests a physician to evaluate a patient, these services are not reimbursable as a consultation. The physician consultant may also initiate diagnostic and/or therapeutic services.

(2) The request for a consultation from the attending physician or other appropriate source as defined in paragraph (E)(1) of this rule and the need for consultation must be documented in the patient's medical record. The

consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source.

(3) A consultation initiated by a patient and/or family, and not requested by a physician, may not be billed using the initial or consultation codes but may be billed using the codes for regular office visits, as appropriate.

(4) If a consultant subsequently assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate evaluation and management services code for the site of service should be reported.

(5) Consultations are subject to the coverage and limitations specified in paragraph (P) of this rule.

(6) Office or other outpatient consultations.

(a) For the reimbursement of consultations provided to patients in an outpatient setting, the provider must bill one of the codes listed in the CPT under office or other outpatient consultation.

(b) When an outpatient consultation code is billed, the provider must submit the required referring physician provider information.

(c) Follow-up visits initiated by and to the consulting physician must be billed using the regular visit codes.

(d) If an additional request for an opinion or advice regarding the same or new problem is received from the attending physician and documented in the medical record, the office and other outpatient consultation codes may be billed.

(7) Inpatient consultations.

(a) Physician consultations provided to a hospital inpatient or ~~a resident of~~ to an individual residing in a long term care facility (LTCF) ~~(in the LTCF setting)~~ must be billed using the codes listed in the CPT under initial inpatient consultations. Only one initial consultation code should be billed by a consultant per admission.

(b) Subsequent consultative visits requested by the patient's attending

physician or subsequent visits required to complete the initial consultation to hospital inpatients or to residents in a LTCF must be billed using the code listed in the CPT for subsequent hospital care or subsequent nursing facility care including services to complete the initial consultation, monitor progress, revise recommendations, or address a new problem.

(c) When an initial inpatient consultation code is billed, the provider must submit the required referring physician provider information.

(F) Emergency department services.

(1) An "emergency department" (sometimes referred to as a "hospital emergency room" or "ER") is defined as an organized, twenty-four-hour, hospital-based facility for the provision of unscheduled episodic services to patients who seek or are in need of immediate medical attention.

(2) Whether or not the provider normally practices in the emergency department setting, evaluation and management services provided in an emergency department must be billed using:

(a) One of the codes listed in the CPT under emergency department services;

(b) The codes for critical care in accordance with paragraph (G) of this rule; and/or

(c) The appropriate surgical procedure codes in accordance with rule 5101:3-4-22 of the Administrative Code.

(3) When ER services are billed using the emergency department E & M codes:

(a) No distinction is made between new and established patients in the emergency department.

(b) ER visits are subject to the coverage and limitations specified in paragraph (P) of this rule.

(4) Surgical codes may be billed in lieu of an E & M service (e.g., code 12006).

(G) Critical care services

(1) Critical care includes the care of critically ill patients as defined in the CPT.

(2) Management of a critically ill patient may be billed using the codes listed in the CPT under critical care services.

(3) Certain services are included in the critical care codes and are not separately reimbursable when the critical care codes are billed. These services are specified in the critical care services section of the CPT.

(4) Critical care begins at the time the physician arrives to begin evaluation and treatment and ends when the physician's presence is no longer required as defined in the CPT.

(a) The critical care codes may be billed to report the total duration of time, to a maximum of two hours, spent by a physician providing constant attention to a critically ill patient even if the time spent by the physician is not continuous on that day.

(b) Code 99291 must be billed to report the first thirty to seventy-four minutes of critical care provided on a given day and code 99292 must be billed to report each additional thirty minutes as defined by the CPT.

(c) If the total duration of time spent with the patient is less than thirty minutes, the provider must bill the appropriate hospital, emergency department, or other visit code.

(d) Inpatient critical care provided to infants twenty-nine days up through twenty-four months of age must be reported with the inpatient pediatric critical care codes 99471 and 99472. These codes must be billed only once per day per physician per patient. Inpatient critical care services provided to neonates twenty-eight days or less should be billed with the inpatient neonatal critical care codes 99468 and 99469 as long as the neonate qualifies for critical services during the hospital stay. Inpatient care for a critically ill or critically injured child older than two years when admitted to an intensive care unit must be billed with hourly critical care codes 99291 and 99292.

(e) Inpatient critical care provided to neonates who are defined as infants twenty-eight days of age or less at the time of admission to a critical care unit, are reported with the neonate critical care codes listed in the CPT book.

(i) Once the neonate is no longer considered to be critically ill, the continuing intensive (non-critical) low birth weight service codes specified in CPT must be used to bill for services subsequent to the day of admission provided by a physician directing the intensive care of the low birth weight or very low birth weight infant who no longer meets the definition of critically ill for those with present body weight of less than five thousand grams, the appropriate E & M code must be billed. When the present body weight of the infant exceeds five thousand grams, bill the appropriate code under subsequent hospital care.

All codes delineated under continuing intensive care services represent subsequent days of care and are reimbursable only once per calendar day per patient. These are considered global codes with the same services bundled as outlined in CPT under "inpatient neonatal and pediatric critical care services."

(ii) Inpatient neonatal and pediatric critical care codes are global twenty-four hour codes and must be billed on a per day basis. Services for a patient who is not critically ill, but happens to be in a critical care unit, must be reported using other appropriate evaluation and management codes.

(iii) Certain procedures are included in the global pediatric and neonatal codes and must not be billed separately. These procedures are specified in the neonatal and pediatric critical care section of the CPT.

(iv) The initial neonatal inpatient critical care code 99468 may be billed as appropriate in addition to 99464 or 99465 when the physician is present for the delivery (99464) and newborn resuscitation (99465) is required. Other procedures performed as part of the resuscitation such as endotracheal intubation (31500) should be billed separately if they are performed as a necessary component of the resuscitation and not as a convenience before admission to the neonatal intensive care unit.

(v) Critical care services provided in the outpatient setting, e.g. emergency department or office for neonates and pediatric patients up through twenty-four months of age, should be billed with the critical care codes 99291 to 99292.

(vi) If the same physician provides critical care services for a neonatal

or pediatric patient in both the outpatient and inpatient settings on the same day, bill only the appropriate neonatal or pediatric critical care code (99471 to 99469) for all critical care services provided that day.

(H) Other evaluation and management service- initial intensive hospital care for the management of a neonate, twenty-eight days of age or less.

(1) Initial hospital care for the evaluation and management of neonates twenty-eight days or less requiring intensive observation, frequent interventions, and other intensive care services are reported under the other evaluation and management services code listed in the CPT book.

(2) Initial hospital care for the evaluation and management of neonates twenty-eight days or less requiring intensive observation, frequent interventions, and other intensive care services is a global twenty-four hour code and must be billed once per admission and on the first day of care.

(3) For the initiation of inpatient hospital care of a normal newborn, or a critically ill neonate, or for initial inpatient hospital care of a neonate not ~~requring~~ requiring intensive observation, frequent interventions, and other intensive care services, bill the codes specified in the CPT.

(4) CPT code 99477 will not be reimbursed when billed on the same date of service with CPT codes 99468 or 99221 through 99223.

(5) Subsequent inpatient hospital intensive care services provided to neonates are reported following CPT guidelines under the subsequent inpatient neonatal critical care code.

(I) Transitional care management services.

(1) These services are for individuals whose medical and or psychosocial problems require moderate or high complexity medical decision making during a transition in care from an acute hospital or other acute care facility setting to the individual's community setting.

(2) Transitional care management is comprised of one face-to-face visit within the specified time frames, in combination with non face-to-face services performed by a physician or other qualified healthcare professional.

(3) Non face-to-face services include but are not limited to communication with the

individual or family member regarding aspects of care, assessment and support of treatment regimen and/ or medication management, identifying available community resources, facilitating access to care or services for the individual, and educating the individual, family member and/ or caregiver.

(4) The complexity of the medical decision making and the date of the first face-to-face visit are used to report the appropriate transitional care management code.

(J) Nursing facility services.

(1) A physician may not be directly reimbursed for a LTCF visit if the service provided is the periodic review of a resident's medical record, plan of care, and/or habilitation plan and a face-to-face encounter with the patient is not provided.

(2) A physician may be reimbursed for one LTCF visit, per patient, per date of service, as detailed in rule 5101:3-3-19 of the Administrative Code and only if the physician personally performed a physical examination on a LTCF resident and documented the visit in the resident's medical record. The guidelines listed in the CPT for LTCF codes must be followed.

(3) A physician may also be reimbursed for a LTCF visit provided by a physician assistant (PA) or nurse practitioner under the physician's employment in accordance with rule 5101:3-3-19 of the Administrative Code.

(K) Domiciliary, rest home (e.g., boarding home) or custodial care services.

Visits provided to patients in a facility that does not meet the definition of a LTCF, such as a domiciliary, rest home, or custodial care service facility, (e.g., boarding home or assisted living facility), that provides room, board and other personal assistance services, must bill using the visit codes listed in the CPT under domiciliary, rest home, or custodial care services.

(L) Domiciliary, rest home, or home care plan oversight services.

Codes listed in this section of the CPT are not separately reimbursable, but are bundled into other services performed.

(M) Home services.

For visits provided to a patient confined to his or her private residence ("homebound patient"), the provider must bill the appropriate code listed in the

CPT under home services.

(N) Newborn care.

(1) Predelivery visit to a pediatrician or other primary care physician.

(a) To encourage families to obtain early and continuous well-child and primary sick care for their newborn, the department will cover a predelivery visit to a pediatrician or other primary care provider of physician services. The purpose of this service is to give the mother (or family) the opportunity to select, and establish a patient relationship with, a physician for the care of her (their) newborn.

(b) For reimbursement of this service, the provider must bill the appropriate evaluation and management code.

(2) The newborn care codes should be used for the following:

(a) The initial history and examination of a normal newborn delivered in a hospital or birthing room setting;

(b) Subsequent hospital care provided to a normal newborn on a per day basis;

(c) Initial history and examination of a normal newborn delivered in a setting other than a hospital or birthing room setting; and

(d) Initial history and examination of a high-risk newborn in accordance with paragraph (N)(3) of this rule.

(3) Pediatrician delivery services for high risk newborns and newborn resuscitation services.

A "high-risk newborn" shall be defined as an infant who is delivered by Cesarean or determined, prior to (or after) the immediate delivery, to be at-risk of prematurity or a poor prognosis.

(a) Services of a pediatrician, when requested by the delivering physician, in attendance at a delivery and for the initial stabilization of a high risk newborn or a Cesarean section may be billed using code 99464. This code cannot be used when the billing physician does any of the

following while in attendance at the delivery:

(i) Provide care or services to other patients;

(ii) Perform a procedure subject to a surgical package; or

(iii) Proctor another physician.

(b) The newborn resuscitation code may be billed only if resuscitation services are actually provided to the newborn. This service involves the provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output.

(c) The newborn resuscitation code and the physician attendance codes may be billed with the codes for newborn care, neonatal intensive care and hospitals visits.

(4) Subsequent care of a sick newborn in an inpatient hospital setting must be billed using the subsequent hospital visit codes or the newborn critical care codes in the CPT.

(5) Routine well baby care provided in an outpatient setting should be billed in accordance with Chapter 5101:3-14 of the Administrative Code.

(6) Subsequent care of a sick newborn in an outpatient setting should be billed using the codes for outpatient E & M services.

(O) Hospital observation services (including admission and discharge services).

(1) The department will recognize initial observation care for patients who are treated in a hospital and the patient's condition does not require an inpatient hospital admission but does require a period of medical observation for less then twenty-two hours . To bill for initial observation care, the provider must bill the appropriate code in the CPT under the initial observation care section.

(2) It is only appropriate to bill hospital observation E & M services provided to patients designated as "observation status" in a hospital. Billing hospital observation services for emergency department services is inappropriate.

(3) For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission should be reported with the

appropriate initial hospital care code.

(4) If patient care during observation services results in a hospital admission and the physician who provided the initial observation care continues to be the patient's attending physician after the admission, the physician must bill the hospital inpatient E & M codes in lieu of the initial observation codes.

(5) If patient care during observation services results in a hospital admission on the same date that observation care was initiated and the physician who provided the observation care does not continue to be the patient's attending physician after the admission, (care is transferred to another physician), the physician who provided the observation care may bill for the initial observation services and the new attending physician may bill a hospital inpatient E&M code.

For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with the appropriate code listed under the "observation or inpatient care services (including admission and discharge services)" section of the CPT.

(6) Do not report an observation discharge in conjunction with a hospital admission.

(7) Observation codes may not be utilized for post-operative recovery if the service is considered a global surgical procedure code.

(P) Limitations on physician visits.

(1) Outpatient visits.

(a) Reimbursement will be made for all physician visits provided to a recipient in an outpatient or an LTCF setting during a calendar year up to a total of twenty-four visits.

(b) Physician visits in excess of twenty-four will be paid as the services are billed to the department but will be subject to post-payment review by the department.

(c) The total number of physician visits accrued by a recipient during a calendar year will be calculated by the department and shall be referred to as the year-to-date visit total.

(d) The following codes will be counted as a physician visit and added to the

recipient's year-to-date visit total, unless the codes are billed on an institutional claim form or institutional electronic transaction or the codes are billed with one of the diagnoses listed in paragraph (P)(1)(d)(vi) of this rule:

(i) Codes 99050 to 99051;

(ii) Codes 99304 to 99310, 99315 to 99318, 99324 to 99328, and 99334 to 99337;

(iii) Codes 99241 to 99255 when the service is provided in a setting other than inpatient hospital;

(iv) Codes 99201 to 99215;

(v) Codes 99281 to 99285; and

(vi) Codes 99341 to 99350.

The year-to-date visit total will be an accumulative total of visits provided by all providers of physician services, including but not limited to all physicians, clinics, and podiatrists.

(e) The following physician visits shall be exempted from counting towards the recipient's year-to-date visit total:

(i) All antepartum and postpartum visits as detailed in rule 5101:3-4-08 of the Administrative Code and all pregnancy related services as detailed in rule 5101:3-4-10 of the Administrative Code;

(ii) All well-child or EPSDT (healthchek) visits as detailed in rule 5101:3-14-04 of the Administrative Code;

(iii) All inpatient hospital and critical care visits as defined in this rule;

(iv) Allergen immunotherapy services not billed in conjunction with a code listed in paragraph (P)(1)(d) of this rule;

(v) All other visits or services billed under a code not listed in paragraph (P)(1)(d) of this rule;

(vi) All visits provided for the following diagnoses:

(a) End-stage renal disease;

(b) Chemotherapy or radiation therapy for malignancy;

(c) End-stage lung disease;

(d) Unstable diabetes or diabetes with complications;

(e) Uncontrolled hypertension or hypertension with complications;

(f) Neoplasms and leukemia;

(g) Organ transplants;

(h) Hereditary anemias;

(i) Hemophilia or other congenital disorders of clotting factors;

(j) Acquired hemolytic anemias;

(k) Aplastic anemias;

(l) Deficiency of humoral immunity;

(m) Deficiency of cell-mediated immunity;

(n) Combined immunity deficiency;

(o) Cystic fibrosis;

(p) Malabsorption;

(q) Failure to thrive;

(r) Infant prematurity;

(s) Respiratory distress syndrome and other respiratory conditions of the fetus and newborn; and

(t) Terminal stage of any life-threatening illness.

(vii) For a visit not to count towards the year-to-date visit total, the provider must bill either a code indicating an exempted service was provided or the visit code with the primary or secondary diagnosis code indicating the patient has one of the exempted conditions.

(f) When the department has paid for more than twenty-four unexempted physician visits for a recipient during a calendar year, information from paid claims history will be reviewed by the department to determine whether the recipient should be referred to a ~~primary care alternative and treatment (PACT) program~~ coordinated services program (which is defined in Chapter 5101:3-20 of the Administrative Code).

(i) In addition, the department or its contractual designees may:

(a) Review the medical records of any recipient exceeding twenty-four visits during a calendar year to determine whether the services were medically necessary and appropriate for the recipient's illness, symptoms or injury; and/or

(b) Conduct an in-depth review of any provider and the provider's medical records if the provider shows an unusual pattern of providing greater than twenty-four visits to medicaid recipients.

(ii) If the department determines that the physician visits were not medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, the payment for the visits may be recovered from the provider by the department.

(2) Inpatient hospital visits.

(a) Inpatient hospital visits, excluding critical care visits, shall be limited to one visit per day per patient per provider.

(b) Critical care visits must be billed in accordance with paragraph (G) of this rule.

(c) Critical care codes may not be billed in conjunction with a hospital or emergency room visit.

~~(3) Visits performed in conjunction with surgical procedures.~~

~~(a) Minimum follow-up period.~~

~~(i) The minimum surgical follow-up period is defined for each surgical procedure under follow-up days in appendix DD to rule 5101:3-1-60 of the Administrative Code.~~

~~(ii) The day of surgery is included in the minimum follow-up period, except when the procedure is identified by an asterisk in appendix DD to rule 5101:3-1-60 of the Administrative Code.~~

~~In the 2004 CPT, the starred procedure designation was removed from surgical codes. Therefore the department has removed the asterisk from most surgical procedures. The department will continue the asterisk designation in appendix DD to rule 5101:3-1-60 of the Administrative Code for a limited number of procedures such as venipuncture procedures.~~

~~*(a)* For those procedures where the asterisk was removed, for claims received on and after January 1, 2004 a follow-up visit will no longer be allowed;~~

~~*(b)* For the venipuncture procedures, which are asterisked in rule 5101:3-1-60 of the Administrative Code, a visit on the same day as surgery will be allowed if the provisions in paragraph (P)(3)(c) of this rule are met.~~

~~(iii) When more than one procedure is performed on the same day, the follow-up period will be equal to the follow-up period of the surgical procedure with the most follow-up days.~~

~~(iv) When another surgical procedure is performed during the follow-up period of a previously performed surgery, the follow-up period will be equal to the follow-up period of the most current surgical procedure or the remaining days left of the follow-up period for the original (or first) surgical procedure, whichever is longer.~~

~~(b) Preoperative visits.~~

(i) Preoperative examinations to evaluate the patient and to determine the necessity of surgery are separately reimbursed when the examination is not performed on the day of surgery.

(ii) All preoperative visits performed by the surgeon after the decision to have surgery is made are included in the global surgical package.

(c) Visits on the same day as surgery.

A provider may be reimbursed for a visit on the same day as surgery, only if the procedure is identified as reimbursable on the same day of surgery in appendix DD to rule 5101:3-1-60 of the Administrative Code and it is customary for the physician to charge a visit for all patients.

(d) Postoperative visits.

(i) Routine postoperative visits.

Reimbursement for all routine postoperative care is included in the physician's reimbursement for surgical procedures.

(a) The physician may not be separately reimbursed for routine postoperative visits provided during the minimum follow-up period.

(b) The physician may not be separately reimbursed for routine postoperative visits, even if the visits occurred after the minimum follow-up period.

(ii) Nonroutine postoperative visits.

(a) A physician may be reimbursed for visits provided during the minimum surgical follow-up period only if the visit was provided after the day of surgery and the visit was provided for the diagnosis and/or treatment of a symptom illness or condition that was unrelated to the surgical procedure (previously) performed.

(b) Visits provided during the minimum surgical follow-up period must be billed as described in this paragraph.

(i) When the visits described in paragraph (P)(3)(d)(ii)(a) of this rule are provided by a physician who did not perform the surgical procedure, the physician may be reimbursed by billing the code for the visit.

~~*(ii)* When the visits described in paragraph (P)(3)(d)(ii)(a) of this rule are provided by the physician who also performed the surgical procedure, the physician may be reimbursed by billing the code for the visit modified by the modifier 24 (unrelated evaluation and management service by the same physician during a postoperative period).~~

~~(e) Visits performed in conjunction with surgical procedures are subject to all other visit limitations defined in this rule.~~

(3) Visits related to surgical procedures.

(a) A preoperative examination related to a particular surgical procedure is not separately reimbursable either when it is performed on the day of surgery or after the decision to have surgery has been made.

(b) For each surgical procedure, a postoperative period, expressed in days, is shown in appendix DD to rule 5101:3-1-60 of the Administrative Code. The day of surgery is included in the postoperative period. For reimbursement purposes, the length of a postoperative period may be adjusted if two surgical procedures are performed within a certain number of days of one another.

(i) If two surgical procedures are performed on the same day, then the longer postoperative period applies to both procedures.

(ii) If a second surgical procedure is performed within the postoperative period of another surgical procedure, then the number of days remaining in the postoperative period of each procedure is set equal to the greater of two figures:

(a) The number of days remaining in the unadjusted postoperative period of the first surgical procedure; or

(b) The number of days remaining in the unadjusted postoperative period of the second surgical procedure.

(c) A blood draw or transfusion procedure performed on the day of surgery is separately reimbursable only if the physician customarily charges all patients for the procedure.

(d) Reimbursement for all routine postoperative care is included in the payment for surgical procedures. A routine postoperative visit is not separately reimbursable even if it is made after the postoperative period has ended.

(e) A nonroutine postoperative visit made to a physician during the postoperative period is separately reimbursable if one of the following conditions is met:

(i) The physician also performed the surgical procedure, and the visit was made for the diagnosis or treatment of a symptom, illness, or condition unrelated to the surgical procedure.

(ii) The physician did not perform the surgical procedure.

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