

INITIAL HOSPITAL VISITS

Issue Date: March 3, 1992

Authority: 32 CFR 199.4(c)(2)(iii)

I. PROCEDURE CODE RANGE

99221 - 99223

Effective January 1, 1992, the American Medical Association Current Procedural Terminology (CPT) evaluation and management service codes (i.e., visit codes) were revised. The former CPT 90000 series codes were replaced by a new CPT 99000 series. These new codes were adopted for claims processing for claims submitted on or after January 1, 1992.

II. DESCRIPTION

An initial hospital visit includes the history, physical examination, development and initiation of a diagnostic and treatment plan, and review and assessment of prior data and records.

III. POLICY

A. An initial hospital visit is covered when provided by an individual professional provider for a covered hospitalization. Only one initial hospital visit is covered for each hospital stay. The level of services is based on the following conditions:

1. Approach and detail of the medical history;
2. Extent of the examination;
3. Complexity of the decision making process;
4. Severity of the presenting problem; and
5. Time spent in direct professional care of the patient.

B. All evaluation and management services provided by a physician in conjunction with a hospital admission are considered part of the initial hospital care when performed on the same date as the admission; e.g., a patient is admitted to a hospital after being treated and/or evaluated in a physician's office or hospital emergency room.

C. Those services provided on the same date at sites other than the hospital are an integral part of initial inpatient care and as such should not be reported separately.

IV. POLICY CONSIDERATIONS

A. Only the attending physician (as provided below) can render and bill for an initial hospital visit. (FOR EXCEPTION ON MENTAL HEALTH ADMISSIONS, See Chapter 1, Section 12.7) In all cases where an attending physician requests the opinion or advice of another physician, that physician's services are to be billed and reimbursed as a consultation. (See Section 8.2 of this Chapter for policy on consultations.)

B. A routine initial hospital visit prior to surgery is generally included in the allowance for the surgical procedure. A separate allowance for the initial hospital visit may be made if:

1. The surgical procedure is designated with an asterisk in the Physicians' Current Procedural Terminology Fourth Edition;

2. A period of time (at least 72 hours) elapsed between admission and surgery, during which time either diagnostic services were required to establish the need for surgery or the patient's condition was stabilized sufficiently to permit surgery.

(See Chapter 1, Section 4.8 for concurrent care provisions.)

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