# 2022 Policy Memo 5

## In-Hospital Medical (Non-Surgical) Care

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## I. Daily Hospital Medical Services (New or Established Patient)

### A. INITIAL AND SUBSEQUENT HOSPITAL CARE

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will follow the American Medical Association Current Procedural Terminology (CPT) guidelines.

### B. INTENSIVE CARE UNIT AND CORONARY CARE UNIT (ICU/CCU) DAYS

If it is a provider's customary practice to make a different charge, regardless of the method of payment, for patients confined in ICU/CCU, the fee will be acknowledged. However, such fees are subject to substantiation by the hospital medical records and charge records in the provider's office. Individual consideration should be requested for any period of more than five (5) consecutive days of ICU or CCU care by submitting the CPT code with modifier 22 and attaching medical records.

Billing for ICU/CCU care is based upon the level of subsequent care days as indicated in CPT.

### C. CRITICAL CARE SERVICES

Critical care includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician. Critical care is usually, but not always, given in a critical care area such as the emergency room. Critical care billings beyond the initial care are to be submitted for individual consideration with records. Such reports include the specific nature of the patient’s condition, details regarding the services rendered and documentation of the amount of time the physician was in direct patient attendance.

### D. DENIED ADMISSIONS AND LEVEL OF CARE

If patient’s admission, continued stay, or level of care is determined to be not medically necessary by pre-certification or claim review, the physician’s services will be denied or adjusted.

### E. PLACE OF SERVICE

The Place of Service must match the institutional billing for claims processing.

## II. In-Hospital Consultations

Consultations are services rendered to give advice or an opinion to a requesting physician about a patient’s condition and management. Medical records must contain documentation of the actual request, the evaluation, and include a copy of the report that is sent to the physician who requested the consultation. Consultations by the same specialty or within the same group are subject to the medical review process. To use the consultation codes, two guidelines apply:

The written or verbal request for a consultation may be made by a physician or other appropriate source and documented in the patient’s medical record. This must include the specific reason for the consultation.

The consultation service must be advice or opinion and the consultant’s findings must be documented in the patient’s medical record. While diagnostic work-up or therapy may be ordered by the consultant, it must be documented in the record and included in the reports to the attending physician.

Documentation is the key component because beginning treatment is considered assuming responsibility for care of the patient. When a consultant assumes responsibility for the patient care (begins treating the patient, schedules follow-up care, etc.) the subsequent services are not consults and must be coded as subsequent hospital visits. Any additional consultation visits must be requested by the attending physician and correctly documented to be coded as additional consults.

A. BCBSKS will follow CPT guidelines for initial consultations.

B. BCBSKS will follow CPT guidelines for follow-up consultations.

C. ADDITIONAL CONSULTATION POLICIES

1. One inpatient consultation may be allowed subject to medical necessity concurrence.
2. Additional consultations for multiple diagnoses may be allowed subject to medical necessity concurrence if the physicians are consulting within their defined specialties.
3. Any follow-up visits by a consultant while the attending physician still serves the patient are considered to be concurrent care and should be billed as such (see Concurrent Professional Care, Policy Memo No. 6).
4. A consultation preceding surgery within the usual preoperative timing would be considered within the surgeon's subsequent fee for the surgery, except in the case of a major classified procedure. Providers agree to accept the review process determination in such cases, subject to the rights to appeal and arbitration.

D. If a physician service is routinely provided to hospice patients, it is not separately billable.