FUTURE Local Coverage Determination (LCD): Evaluation and Management Services Provided in a Nursing Facility (L35068)

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Please note: Future Effective Date.

Contractor Information

Contractor Name	Contract Number	Contract Type	Jurisdiction
Novitas Solutions, Inc.	04412	A and B MAC	J - H

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LCD Information

Document Information

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L35068

Original ICD-9 LCD ID
L27496

LCD Title
Evaluation and Management Services Provided in a Nursing Facility

Jurisdiction
Texas

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For services performed on or after 10/01/2015

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CMS National Coverage Policy This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for evaluation and management services (E/M) provided in a nursing facility. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for E/M services provided in a nursing facility and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding E/M services provided in a nursing facility are found in the following Interne-Only Manuals (IOMs) published on the CMS Web site:

CMS On-line Manual Pub. 100-03, Chapter 1, Section 70.3

CMS On-line Manual Pub. 100-4, Chapter 12, Section 30.6.10

CMS On-line Manual Pub. 100-4, Chapter 12, Section 30.6.13

CFR 42 483.40 Physician services

CMS Change Request 6705, Expansion of Medicare Telehealth Services for CY 2010.

Social Security Act (Title XVIII) Standard References:

Title XVIII of the Social Security Act, Section 1819 (b)(6)(A). The section outlines statute for Skilled Nursing Facilities.

Title XVIII of the Social Security Act, Section 1919 (b)(6)(A). This section outlines statue for Nursing Facility.

Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

The services addressed by this policy are described by the CPT codes listed below that are used to report the services provided in the facility to residents of nursing facilities who require initial nursing facility care, subsequent nursing facility care, consultation services in a nursing facility or annual assessments.

Change Request 6740, Revisions to Consultation Services Payment Policy, dated 12/14/2009 (CMS Pub. 100-04, Medicare Claims Processing Manual), discusses CPT codes *99251, 99252, 99253, 99254, and 99255*; effective 01/01/2010 these codes are not recognized for Medicare Part B payment. Additional information is available in the MLN Matters article MM6740.

Change Request 6705, Expansion of Medicare Telehealth Services for CY 2010, discusses consultative services furnished via telehealth to beneficiaries in SNFs. Please refer to CR 6705 for details; Tr118 and Tr1881.

Indications

Initial Nursing Facility Care *(99304, 99305, and 99306)*

Initial nursing facility care includes all evaluation and management services performed by the same physician or group done in conjunction with that admission when performed on the same date as the admission or readmission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting.

The initial visit in a skilled nursing facility (SNF) and nursing facility (NF) must be performed by the physician except as otherwise permitted (42 C.F.R. 483.40 (c) (4)). The initial visit is defined as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, the visit must occur no later than 30 days after admission.

Further, per the Long Term Care regulations at 42 CFR 483.40 (c)(4) and (e)(2), the physician may not delegate a task that the physician must personally perform. Therefore, the physician may not delegate the initial visit in a SNF. This also applies to the NF with one exception.

The only exception, as to who performs the initial visit, relates to the nursing facility (NF) setting. In the NF setting, a qualified non physician practitioner (NPP) such as a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS), who is not employed by the facility, may perform the initial visit when the State law permits this. The E/M visit must be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision must be met.

Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure and billing are met.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (nursing facility) if the patient does not have Part A SNF benefits or if the patient is in a NF or in a non-covered SNF stay (e.g., there was no preceding 3-day hospital stay). The CPT Nursing Facility code definition also includes POS 54 (Intermediate Care Facility/Mentally Retarded) and POS 56 (Psychiatric Residential Treatment Center).

Initial Nursing Facility Care, per day, *(99304, 99305, and 99306)* shall be used to report the initial visit. Only a physician may report these codes for an initial visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above).

A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility. As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

Subsequent Nursing Facility Care *(99307, 99308, 99309, and 99310)*

Coverage for subsequent nursing facility care for evaluation of specific medical conditions will be considered reasonable and necessary if they would require the skill of a physician or non-physician practitioner (i.e., nurse practitioner, physician assistant, where permitted by state licensure) to evaluate the patient in a face-to-face contact. These codes are described as CPT codes *99307, 93308, 93309, and 93310*.

In the nursing home environment, patients are in a controlled environment in which they are under close supervision and have immediate access to care from trained medical professionals. Under these circumstances, it is customary for physicians to direct nursing home personnel to perform, in the absence of the physician, many of those services that may be necessary but of a relatively minor nature. Frequent visits by the physician under these circumstances would then be unnecessary, particularly if the patient is medically stable. However, it would not be unreasonable for the attending physician to make several visits at the time of a new episode of illness or an acute exacerbation of a chronic illness. The medical record should clearly reflect the particular circumstances requiring the increased frequency of services by documenting the following:

- patient instability or change in condition that the physician documents is significant enough to require a timely medical or mental status evaluation and/or physical examination to establish the appropriate treatment intervention and/or change in care plan;
- therapeutic issues that the physician documents require a timely follow-up evaluation to assess effectiveness of therapy or treatment - for example, recent surgical or invasive diagnostic procedures, pressure ulcer evaluation, psychotropic medication regimens, or (for the terminally ill) comfort measures;
- medical conditions including delirium, dementia, or changes in mental status manifest with behavioral symptoms that require timely evaluation; and
- nursing staff, rehabilitation staff, patient, or family requests to address a documented medical issue of concern that requires a physical (or mental status) examination.

The following clinical situations are examples of conditions where more frequent visits may be considered reasonable and necessary:

- Stage III or IV pressure sore-healing
- Management of acute exacerbation of unstable COPD
- Management of acute exacerbation of unstable angina
- Management of acute exacerbation of unstable diabetes
- Acute infection
- Acute behavioral cognitive and/or functional changes

The medical record must clearly reflect the medical necessity of the service, as well as the key components necessary to report the particular level of care reported.

Visits to Comply With Federal Regulations in the SNF and NF *(99307, 99308, 99309, 99310, and 99318)*

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial visit by the physician, payment may be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Subsequent Nursing Facility Care, per day, *(99307, 99308, 99309 and 99310)* shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

Contractors may not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a "per day" service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit

occurs). The physician/qualified NPP shall bill only one E/M visit.

The CPT code *99318* describes the evaluation and management of a patient involving an annual nursing facility assessment. This code should be used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. For Medicare Part B payment policy, an annual assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code *99318* are fully met and in lieu of reporting a Subsequent Nursing Facility Care, per day, service codes *99307, 99308, 99309, and 99310*. It shall not be performed in addition to the required number of federally mandated physician visits. The CPT annual assessment code does not represent a new benefit service for Medicare Part B physician service.

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF, may perform federally mandated physician visits, at the option of the State, after the initial visit by the physician.

Medicare Part B payment policy does not pay for additional visits that may be required by State law for an admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial physician visit, that are reasonable and medically necessary to meet the medical needs of the individual resident (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

Visits by Qualified Nonphysician Practitioners

All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. CPT codes, Subsequent Nursing Facility Care, per day *(99307, 99308, 99309, and 99310)*, shall be reported for these E/M visits even if the visits are provided prior to the initial visit by the physician.

SNF Setting Place of Service Code 31

Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

Medically Complex Care

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 E/M visits using the Subsequent Nursing Facility Care, per day (codes *99307, 99308, 99309, and 99310*) for these E/M visits even if the visits are provided prior to the initial visit by the physician.

SNF/NF Discharge Day Management Service *(99315 and 99316)*

Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the

qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. The CPT code *99315 or 99316* shall be reported for this visit. The Discharge Day Management Service may be reported using CPT code *99315 or 99316*, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

Inpatient Consultative or Specialist Services, Including Second Opinion E/M Service Requests

Consultative or specialist services are allowed when they address a documented diagnostic or therapeutic question of which the attending physician determines he or she needs the assistance or second opinion of a specialist (by a record review and a physical and/or cognitive examination) to assess the condition. Only one initial specialist service should be reported by each specialist per admission. When ordering specialist services, the following elements need to be considered:

- A consulting specialist should possess an additional knowledge base and/or skills clearly outside the skill/knowledge base of that primary care attending physician, unless the consultation is for a second opinion.
- The service requested must be appropriate for the specific individual.
- The service will affect the resident/patient assessment, diagnosis or care planning or treatment.

As per MLN Matters® article MM6740: "Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes."

As per CR 6740, effective January 1, 2010, consultation CPT codes *99251, 99252, 99253, 99254, and 99255* are not recognized for Medicare Part B payment. The CR states: "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 …nursing facility setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the … nursing facility care codes *(99304, 99305, and 99306)*." Please note this CR and MM6740 outlines the proper use of AI modifier as well. Later it states: "Follow-up visits in the facility setting shall be billed as … subsequent nursing facility care visits." These are represented by codes *99307, 99308, 99309, and 99310.* Also, "All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services."

A second opinion, for Medicare purposes, is generally performed as a request for a second or third opinion of a previously recommended medical treatment or surgical procedure. A second opinion E/M service is generally a request by the patient and/or family or mandated (e.g., by a third-party payer), and not requested by a physician or qualified NPP. That said, the actual request (or order) for the service would generally be made through the attending physician or physician of record. The CPT modifier -32 (Mandated Services) is not recognized as a payment modifier in Medicare. A second opinion evaluation service to satisfy a requirement for a third party payer is not a covered service in Medicare.

Incident to Services

Where a physician establishes an office in a SNF/NF, the "incident to" services and requirements are confined to this discrete part of the facility designated as his/her office. "Incident to" E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Thus, visits performed outside the designated "office" area in the SNF/NF would be subject to the coverage and payment rules applicable to SNF/NF setting and shall not be reported using the CPT codes for office or other outpatient visits or use place of service code 11.

Group Visits

The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient (refer to §§1862 (a)(1)(A) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits. The E/M visit (Nursing Facility Services) represents a "per day" service per patient as defined by the CPT code. The medical record must be personally documented by the physician or

qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.

Split/Shared E/M Service

A split/shared E/M visit cannot be reported in the SNF/NF setting. A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.

Limitations

- Indications not listed in the "Indications and Limitations of Coverage" section of this policy.
- The service was not directly provided by the physician or non-physician practitioner
- The service was provided without face-to-face interaction with the patient.
- The medical record documentation does not clearly satisfy the Medicare criteria for "Reasonable and Necessary".
- The service is covered under a contract with the nursing home.
- The service is a bundled part of facility services furnished to Medicare beneficiaries in the participating facility.
- Follow-up sub specialty and/or specialized care not clearly documented in the medical record to reflect the medical necessity of the service(s) rendered.
- Consecutive daily or courtesy visits not reasonable and necessary for follow-up.
- The service is for non-covered screening purposes.
- The service is not medically necessary.
- The medical record does not verify that the service described by the CPT/HCPCS code was provided.

Italicized and/or quoted material is excerpted from the American Medical Association, Current Procedural Terminology (CPT) codes.

As published in CMS IOM 100-08, Chapter 13, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862 (a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and Effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
    - Furnished in a setting appropriate to the patient's medical needs.
    - Ordered and furnished by qualified personnel.
    - One that meets, but does not exceed, the patient's medical needs.
    - At least as beneficial as an existing and available medically appropriate alterative.

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Coding Information

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Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

999x Not Applicable

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999 Not Applicable

CPT/HCPCS Codes
Group 1 Paragraph: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

Group 1 Codes:
99304 Nursing facility care init
99305 Nursing facility care init
99306 Nursing facility care init
99307 Nursing fac care subseq
99308 Nursing fac care subseq
99309 Nursing fac care subseq
99310 Nursing fac care subseq
99315 Nursing fac discharge day
99316 Nursing fac discharge day
99318 Annual nursing fac assessmnt

ICD-10 Codes that Support Medical Necessity
Group 1 Paragraph: It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Group 1 Codes:

ICD-10 Codes	**Description**
XX000	Not Applicable

ICD-10 Codes that DO NOT Support Medical Necessity N/A
ICD-10 Additional Information

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General Information

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Associated Information

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record should support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.
5. Documentation should detail the specific elements of the E/M service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information may be denied.

Appendices

N/A

Utilization Guidelines

In accordance with CMS ruling 95-1(V), utilization of the service(s) should be consistent with locally acceptable standards of practice.

Sources of Information and Basis for Decision

Contractor is not responsible for the continued viability of websites listed.

American Medical Directors Association, "White Paper on 'Determination and Documentation of Medical Necessity in Long Term Care Facilities," October 31, 1999

American Medical Association CPT Assistant, Volume 8, Issue 5; May 1998

Other Contractor's Policies

Contractor Medical Directors

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Revision History Information

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
10/01/2015	R1	LCD revised to create uniform LCD with other MAC jurisdiction.	• Creation of Uniform LCDs With Other MAC Jurisdiction

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Associated Documents

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

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Keywords

N/A Read the **LCD Disclaimer** Back to Top