Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

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Nursing Facility Services (Codes 99304 - 99318)

Note: This article was updated on October 23, 2012, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians and non-physician practitioners (NPPs) and physicians assistants

Provider Action Needed

STOP – Impact to You

In both the skilled nursing facility (SNF) and nursing facility (NF) settings, qualified non-physician practitioners (NPP), i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS), may provide certain defined beneficiary visits prior to, and after, the physician performs the initial visit. In addition, in the NF setting, when certain requirements are met, an NPP not employed by the NF may also perform the initial visit itself.

In addition, effective January 1, 2006, Current Procedural Terminology (CPT) codes (99301 - 99303) for reporting the initial nursing facility care and subsequent nursing facility care (99311-99313) are deleted, and are replaced by new codes (see below).

CAUTION – What You Need to Know

CR4246, from which this article is taken, conveys that, in both the SNF and NF settings, a qualified NPP may provide covered medically necessary visits prior to and after the physician performs the initial visit. Qualified NPPs may provide federally mandated visits (after the initial visit by the physician and as permitted under the Long Term Care Regulations). Further, it provides that, when specific requirements are met in the NF setting, an NPP who is not employed by the NF and who is permitted by State law may perform the beneficiary's initial visit.

It also clarifies the distinction between required (i.e., federally mandated) and medically necessary visits, "incident to" services, prolonged services, split/shared E/M services, gang visits, and the SNF/NF discharge day management services. The CR revises the *Medicare Claims Processing Manual,* Publication 100-04, Chapter 12, Section 30.6.13, with new CPT codes for reporting visits in the skilled nursing facility (SNF) or nursing facility (NF)settings: Initial Nursing Facility Care (codes 99304 – 99306); Subsequent Nursing Facility Care (codes 99307 – 99310 and Other Nursing Facility Services (CPT code 99318 for an annual assessment).


GO – What You Need to Do

Make sure that your billing staffs are aware of these changes.

Background

To begin this discussion, remember that the Medicare Statute is the basis for distinguishing between delegation of physician visits and tasks in skilled nursing facilities (SNF -- Place of Service Code 31, for patients in a Part A SNF stay), and nursing facilities (NF -- Place of Service Code 32, for patients who do not have Part A SNF benefits, patients who are in a Nursing Facility or in a non-covered SNF stay).

To the point, Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. (For further information, refer to MLN Matters article number SE0418 at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0418.pdf* on the CMS website.

Payment Policy for E/M Visits

CR4246 clarifies payment policy (effective January 1, 2006) for evaluation and management (E/M) visits by physicians and qualified NPPs (i.e., nurse practitioners [NP], physician assistants [PA], or clinical nurse specialists [CNS]) in SNF and NF settings:

Delegation of the Initial Visit

First, CR4246 clarifies the policy for the delegation of the initial visit in the NF setting. Remember that the initial visit in both SNFs and NFs is defined (per the Survey and Certification memorandum (S&C-04-08), dated November 13, 2003) 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.

It must occur no later than 30 days after admission. In the SNF setting, the physician must perform this initial visit. In the NF setting, a qualified NPP, not employed by the NF, may perform the initial visit when permitted by state law, and

when (as in all Evaluation & Management visits) the NPP meets all Medicare and physician collaboration and supervision requirements, and the service falls within the scope of practice and licensure for the state where the service occurs. (Physician assistants, additionally, must meet the general physician supervision requirement as well as employer billing requirements.)

After the Initial Visit

In the SNF setting, after the initial visit by the physician, physicians may delegate alternating federally mandated physician visits to qualified NPPs (whether they are employed or not by the SNF).

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

Physician Delegation of Medically Necessary Visits to Qualified NPPs

Also, CR4246 clarifies physician delegation of medically necessary visits to qualified NPPs in the SNF and NF settings. In both of these settings, if all the requirements for collaboration, physician supervision, licensure, and billing are met, qualified NPPs may perform medically necessary E/M visits (those visits necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member) prior to, and after, the physician's initial visit.

General physician supervision and employer billing requirements shall be met for PA services. The PA must also meet the state scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary E/M Visits

Medically necessary E/M visits are payable under the physician fee schedule under Medicare Part B.

> Note: 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 or qualified NPP shall report only one E/M visit.

New Code Changes to Medicare Claims Processing Manual

CR4246 also revises the *Medicare Claims Processing Manual,* Pub.100-04, Chapter 12, Section 30.6.13, with new code changes made by the American Medical Association (AMA) Current Procedural Terminology (CPT) 2006 for services reported in a nursing facility.

Beginning January 1, 2006, CPT codes for reporting the initial nursing facility care and subsequent nursing facility care are deleted and replaced by new ones.

The new codes that physicians and qualified NPPs should use for SNF and NF visits are as follows:

CPT Codes 99304-99306 – Initial Nursing Facility Care

As of January 1, 2006, CPT codes 99304-99306 (Initial Nursing Facility Care, per day) shall be used to report the initial visit. CPT codes 99301 – 99303 are deleted after 12/31/05.

Only a physician may report 99304-99306 for an initial visit performed in an SNF or NF except for (as explained above) those performed by a qualified NPP in the NF setting who is not employed by the facility and when state law permits.

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

Codes 99307-99310 – Subsequent Nursing Facility Care

Codes 99307-99310 (Subsequent Nursing Facility Care, per day) shall be used to report federally mandated physician visits and other medically necessary visits. These codes are effective January 1, 2006, and replace codes 99311-99313 which are deleted after 12/31/05.

Medicare will pay 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. You shall also use these codes to report medically necessary E/M visits even if they are provided prior to the initial visit by the physician.

You shall also use these codes to report medically complex care in an SNF upon discharge from an acute care visit, again even if the visits are provided prior to the physician's initial visit.

Codes 99315-99316 – Discharge Day Management Service

Codes 99315-99316 (Discharge Day Management Service) shall be used to report the physician or NPP's face-to-face visit with the patient to meet the SNF/NF discharge day management service requirement. You shall report the visit as the actual date of the visit even if the patient is discharged from the facility on a different calendar date.

These codes may be used (depending on the code requirement) to report a death pronouncement of a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

Code 99318 – Other Nursing Facility Service

Code 99318 (Other Nursing Facility Service) shall be used to report an annual nursing facility assessment visit on the required schedule of visits if an annual assessment is performed. For Medicare Part B payment policy, an annual assessment visit code shall substitute as meeting (but not be in addition to) 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 code

(codes 99307 – 99310). This new code does not represent a new benefit service for Medicare Part B physician services.

Other Important Information to Remember

- Medicare will pay for 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), but will 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.
- A physician (or qualified NPP, where permitted, as discussed above) who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment, or may reassign payment for his/her professional service to the facility. However, a PA's employer must always report the visits that the PA performs.
- As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.
- The Prolonged Services (CPT codes 99354 – 99357) shall not be reported with Nursing Facility Services beginning January 1, 2006 until further notice. The new AMA CPT codes do not have typical/average time units established.
- E/M visits for counseling/coordination of care, for Nursing Facility Services, that are time-based must be billed based on the key components of an E/M service (history, exam and medical decision making) until the AMA CPT creates typical/average time units for the Nursing Facility Services.

Other Visit Information

- "Incident to" E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Where a physician establishes an office in a facility, the "Incident to" E/M visits and requirements are confined to this discrete part of a SNF/NF designated as his/her office. The place of service (POS) on the claim should be "office" (POS 11).
- Thus, visits performed outside the designated "office" area in the SNF/NF are subject to SNF/NF setting coverage and payment rules and shall not be reported using the CPT codes for office or other outpatient visits or use POS code 11.
- "Gang visits" (claims for an unreasonable number of daily E/M visits by the same physician to multiple residents at a facility within a 24-hour period) may result in medical review to determine medical necessity for the 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. The E/M visit (Nursing

Facility Services) represents a "per day" service per patient as defined by the CPT code. The physician or qualified NPP who performed the E/M visit must personally document the service in the medical record, and the documentation should support the specific level of E/M visit to each individual patient.

- Split/shared E/M visits cannot be reported in the SNF/NF setting. A split/shared visit is defined as a medically necessary patient encounter in which the physician and a qualified NPP each personally perform a substantive portion of an E/M visit (all or some portion of the history, exam or medical decision making key components of an E/M service) face-to-face with the same patient on the same date of service.
- A split/shared E/M service 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).

Additional Information

For further reference on Survey and Certification issues applicable to the SNF/NF settings refer to MLN Matters article number SE0418 at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0418.pdf on the CMS website.

To view the official instruction (CR4246) issued to your carrier or fiscal intermediary, please visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R808CP.pdf on the CMS website. You might also want to look at the Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 30.6.13 (Nursing Facility Services (Codes 99304 - 99318), which you can find as an attachment to CR4246.

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.

Finally, if you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.