Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1714

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
15509.1 - 15510	15-88.1 - 15-88.2 (2pp.)	15-88.1 -15-88.2 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2000*
IMPLEMENTATION DATE: June 4, 2001

Section 15510,. Home Care And Domiciliary Care Visits (Codes 99321 - 99353), is changed to correct an error made in the original publication of this section in Transmittal #1690. POS codes 32 and 56 were incorrectly included under Domiciliary, Rest Home or Custodial Services. They are correctly included under Nursing Facility Services in this change.

Carriers need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, carriers should adjust claims brought to their attention.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

15509.1 Payment For Physician's Visits To Residents Of Skilled Nursing Facilities and Nursing Facilities.--

A. Visits to Perform Resident Assessments.--Pay for visits necessary to perform all Medicare required assessments. Physicians should use the CPT codes for comprehensive nursing facility assessments (99301-99303) to report evaluation and management services involving comprehensive resident assessments. Evaluation and Management documentation guidelines apply. (See §15510 for further clarification on use of SNF/NF codes.)

B. Visits to Comply With Federal Regulations (42 CFR 483.40).--Pay for visits required to 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. These visits and all other medically necessary visits for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered under Medicare Part B. Physicians should use CPT codes for subsequent nursing facility care (99311-99313) when reporting evaluation and management services that do not involve resident assessments. Medicare does not pay for additional visits required by State law for an admission unless the visits are necessary to meet the medical needs of the individual resident.

C. Medically Complex Care.--Pay for visits to residents in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are medically necessary and documented in the medical record. Physicians should use CPT codes for subsequent nursing facility care (99311-99313) when reporting evaluation and management services.

D. Visits by Non-Physician Practitioners.--Visits to comply with Federal Regulations (see 15509.1B) in SNFs after the initial visit by the physician may, at the option of the physician, be provided by a non-physician practitioner, i.e., physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS). (Refer to 42 CFR 483.40(4) and (e).)

Any medically necessary physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied, when performed by an NP, PA or CNS (at the option of the State) who is not an employee of the facility in which they practice. (Refer to 42 CFR 483.40 (f).)

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" services may not be billed in an hospital setting. Thus, services performed outside the "office" area would be subject to the coverage rules applicable to services provided outside the office setting, i.e., nursing home. (Refer to CIM 45-15.)

Services provided by physician-employed or independent non-physician practitioners must meet Medicare requirements and fall within the scope of services that practitioners are licensed to perform. A physician assistant must be under the general supervision of the physician. These visits and all other medically necessary visits for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered under Medicare Part B.

E. Gang Visits.--Although the selection of the level of service for an evaluation and management encounter is not based on time, the CPT codes provide an approximate time typically spent with a resident. The level of service and code billed must be medically necessary (§§1862 (a)(1)(A)of the Social Security Act) for each resident. Claims for an unreasonable number of visits to residents at a facility within a 24-hour period may indicate an aberrancy and result in medical review to determine medical necessity. Medical records must document the specific services to each individual resident.

15510. HOME CARE AND DOMICILIARY CARE VISITS (CODES 99321-99353)

A. Physician Visits to Patients Residing in Various Places of Service.--Current Procedural Terminology (CPT) codes 99321 through 99333, domiciliary, rest home (e.g., boarding home), or custodial care services, are used to report evaluation and management (E/M) services to residents residing in a facility which provides room, board, and other personal assistance services, generally on a long- term basis. These codes are limited to the specific two digit places of service (POS) 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Facility). These facilities are often referred to as adult living facilities or assisted living facilities.

Physicians and providers furnishing E/M services to residents in a living arrangement described by one of the POS listed above must use the level of service code in the range of codes 99321- 99333 to support the service they provide.

CPT codes 99341 through 99350, home services codes, are used to report E/M services furnished to a patient residing in his or her own private residence and not any type of facility. These codes apply only to the specific two digit POS 12 (Patient's Home). Home Services codes, CPT codes 99341 through 99350, may not be used for billing for E/M services provided other than in the private residence of an individual.

Evaluation and Management services provided to patients residing in a Skilled Nursing Facility ((SNF) (CPT definition formerly identified as SNFs, intermediate care facilities (ICFs), or long term care facilities (LTCFs) must be reported using the appropriate level of service code within the range identified for Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care services. Codes range from 99301 through 99303 for the former and 99311 through 99313 for the latter, and Nursing Facility Discharge Services codes 99315 - 99316. These codes are limited to the specific two digit POS 31 (SNF), 32 (Nursing Home/Nursing Facility), 54 (Intermediate Care Facility/Mentally Retarded) and 56 (Psychiatric Residential Treatment Center).

15511. PROLONGED SERVICES AND STANDBY SERVICES (CODES 99354-99360)

15511.1 Prolonged Services (Codes 99354 - 99355).--

A. Required Companion Codes.--Pay prolonged services codes 99354-99355 when they are billed on the same day by the same physician as the companion evaluation and management codes and:

- The companion codes for 99354 are 99201-99205, 99212-99215, or 99241-99245;
- The companion codes for 99355 are 99354 and one of the evaluation and management codes required for 99354 to be used;
- The companion codes for 99356 are 99221-99223, 99231-99233, 99251-99255, 99261-99263, 99301-99303, or 99311-99313; or
- The companion codes for 99357 are 99356 and one of the evaluation and management codes required for 99357 to be used.

Do not pay prolonged services codes 99354-99358 unless they are accompanied by one of these companion codes.