## Local Coverage Determination (LCD):
**Evaluation and Management Services in a Nursing Facility (L36230)**

### Contractor Information

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<tr>
<th>Contractor Name</th>
<th>Contract Type</th>
<th>Contract Number</th>
<th>Jurisdiction</th>
<th>State(s)</th>
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<td>A and B MAC</td>
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### LCD Information

**Document Information**

- **LCD ID**: L36230
- **LCD Title**: Evaluation and Management Services in a Nursing Facility
- **Proposed LCD in Comment Period**: N/A
- **Source Proposed LCD**: DL36230

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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 or skilled nursing facility. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy and are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replaces, modifies, or supersedes 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 or skilled 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 and skilled nursing facility are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

CMS Center for Clinical Standards and Quality/Survey & Certification Group, Ref.: S&C: 13-15-NH
CMS Internet-only Manuals (IOM), Medicare Claims Processing Manual, Pub 100-04, Chapter 12, Sections 30.6.1, 30.6.10 & 30.6.13
CMS Internet-only Manuals (IOM), Medicare National Coverage Determination, Pub 100-03, Chapter 1, Section 70.3
CMS Internet-only Manuals (IOM), Medicare Program Integrity Manual, Pub 100-08, Chapter 13, Section 13.5.1
CMS Internet-only Manuals (IOM), Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, Section 270.2
Code of Federal Regulations 42 483.40 Physician services

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Indications

Initial Nursing Facility Care

Initial nursing facility care includes all evaluation and management services (E/M) 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 (S&C) 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) in a SNF, the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C: 13-15-NH, the physician may not delegate the initial comprehensive visit in a SNF. The only exception, as to who performs the initial visit, relates to the 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 shall 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 shall 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 (NF) 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**

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 (where permitted by state licensure) to evaluate the patient in a face-to-face contact.

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 must 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 manifested 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
- acute fall or injury

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

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNF’s while section 1919 (b) (6) (A) of the Act governs NF’s. The federally mandated visits in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4) and (f)). The principal physician of record must append the modifier “-AI” (Principal Physician of Record) to the initial nursing facility care code. This modifier will identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. All other physicians or qualified NPPs who perform an initial evaluation in the NF or SNF may bill the initial nursing facility care code. The initial federally mandated visit is defined in S&C: 13-15-NH as the initial comprehensive 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.

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician or qualified NPP where permitted, payment shall 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 shall 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 nursing facility 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 code (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 a 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 a facility 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 patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

Visits by Qualified Non Physician 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. A physician or NPP may bill the most appropriate initial nursing facility care code (99304, 99305, 99306) or subsequent nursing facility care code (99307, 99308, 99309, and 99310), even if the E/M service is provided prior to the initial federally mandated visit.

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 federally mandated 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 the initial nursing facility care codes for their first visit with the patient. The principal physician of record must append the modifier "AI" Principal Physician of Record, to the initial nursing facility care code when billed to identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. Follow-up visits shall be billed as Subsequent Nursing Facility Care, per day (codes 99307, 99308, 99309, and 99310) codes.

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.

Multiple 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.

Consultation Services

Effective January 1, 2010, consultation codes are no longer recognized for Medicare Part B payment. 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) may bill the most appropriate initial nursing facility care code (99304, 99305, and 99306) or subsequent nursing facility care code (99307, 99308, 99309, 99310) that reflects the services the physician or practitioner furnished.

**SNF/NF Discharge Day Management Service**

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. 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.

**Limitations**

- Indications that are 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 subspecialty and/or specialized care is/are not clearly documented in the medical record to reflect the medical necessity of the service(s) rendered.
- Consecutive daily or courtesy visits are not reasonable and necessary for follow-up.
- The service is for non-covered screening purposes.
- The medical record does not verify that the service described by the CPT/HCPCS code was provided.

**Coding Information**

**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.

N/A

**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.

N/A

**CPT/HCPCS Codes**

**Group 1 Paragraph:** N/A

**Group 1 Codes:**

99304  INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED OR COMPREHENSIVE HISTORY; A DETAILED OR COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING
THAT IS STRAIGHTFORWARD OR OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION ARE OF LOW SEVERITY. TYPICALLY, 25 MINUTES ARE SPENT AT THE BEDSIDE AND ON THE PATIENT'S FACILITY FLOOR OR UNIT.

99305 INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION ARE OF MODERATE SEVERITY. TYPICALLY, 35 MINUTES ARE SPENT AT THE BEDSIDE AND ON THE PATIENT'S FACILITY FLOOR OR UNIT.

99306 INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION ARE OF HIGH SEVERITY. TYPICALLY, 45 MINUTES ARE SPENT AT THE BEDSIDE AND ON THE PATIENT'S FACILITY FLOOR OR UNIT.

99307 SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED INTERVAL HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT IS STABLE, RECOVERING, OR IMPROVING. TYPICALLY, 10 MINUTES ARE SPENT AT THE BEDSIDE AND ON THE PATIENT'S FACILITY FLOOR OR UNIT.

99308 SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED INTERVAL HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT IS RESPONDING INADEQUATELY TO THERAPY OR HAS DEVELOPED A MINOR COMPLICATION. TYPICALLY, 15 MINUTES ARE SPENT AT THE BEDSIDE AND ON THE PATIENT'S FACILITY FLOOR OR UNIT.

99309 SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT HAS DEVELOPED A SIGNIFICANT COMPLICATION OR A SIGNIFICANT NEW PROBLEM. TYPICALLY, 25 MINUTES ARE SPENT AT THE BEDSIDE AND ON THE PATIENT'S FACILITY FLOOR OR UNIT.

99310 SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. THE PATIENT MAY BE UNSTABLE OR MAY HAVE DEVELOPED A SIGNIFICANT NEW PROBLEM REQUIRING IMMEDIATE PHYSICIAN ATTENTION. TYPICALLY, 35 MINUTES ARE SPENT AT THE BEDSIDE AND ON THE PATIENT'S FACILITY FLOOR OR UNIT.

99315 NURSING FACILITY DISCHARGE DAY MANAGEMENT; 30 MINUTES OR LESS

99316 NURSING FACILITY DISCHARGE DAY MANAGEMENT; MORE THAN 30 MINUTES

99318 EVALUATION AND MANAGEMENT OF A PATIENT INVOLVING AN ANNUAL NURSING FACILITY ASSESSMENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY;
A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING THAT IS OF LOW TO MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT IS STABLE, RECOVERING, OR IMPROVING. TYPICALLY, 30 MINUTES ARE SPENT AT THE BEDSIDE AND ON THE PATIENT'S FACILITY FLOOR OR UNIT.

G9685 THIS CODE IS FOR THE EVALUATION AND MANAGEMENT OF A BENEFICIARY'S ACUTE CHANGE IN CONDITION IN A NURSING FACILITY

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:**

<table>
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<th>ICD-10 Codes</th>
<th>Description</th>
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<td>XX000</td>
<td>Not Applicable</td>
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ICD-10 Codes that DO NOT Support Medical Necessity

Additional ICD-10 Information

N/A

General Information

**Associated Information**

**Documentation Requirements**

1. As stated in the Centers for Medicare & Medicaid Services (CMS) Internet-only Manuals (IOM) 100-04, Chapter 12, Section 30.6.1, medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during or as soon as practicable after it is provided in order to maintain an accurate medical record.

2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service). 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 must support the use of the selected diagnosis code(s). The submitted CPT/HCPCS code must describe the service performed.

4. Documentation must detail the specific elements of the E/M service for the patient on the day of service. It must be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information that does not clearly support medical necessity will be denied.

5. When services are provided in ANY setting, Medicare's medically reasonable and necessary criteria must be met, unless it is determined as a federally mandated visit, as stated in the section of the LCD for “Visits to Comply with Federal Regulations in the SNF and NF.” Standing visits (e.g., standing order “every 3 months”) are not considered medically necessary unless the patient’s medical condition is clearly documented, and they are only considered medically necessary when they relate to acceptable standards of medical practice or published medical guidelines for a specific diagnosis. This must be validated each time by a statement documented in the clinical record of the patient’s status. The medical records submitted for review must clearly support the medical necessity of the visit, as well as, the level of E/M service billed.
6. Many elderly patients have chronic conditions such as hypertension, diabetes, orthopedic conditions, and abnormalities of the toenails. The mere presence of inactive or chronic conditions does not constitute medical necessity for any setting. There must be a chief complaint or a specific reasonable and medically necessary need for each visit. In support of this, the documentation of each patient encounter must include the following:
   ◦ reason for the encounter and relevant history;
   ◦ physical examination findings and prior diagnostic test results, if applicable;
   ◦ assessment, clinical impression, or diagnosis; and
   ◦ medical plan of care.

Thus, a payable diagnosis alone does not support medical necessity of ANY service.

7. Medical necessity must exist for each individual visit and must not be a visit of convenience (unless the medical record clearly documents the necessity for the visit). The initial visit and the reason for subsequent visits must not be driven by group visits to one facility without other factors as mentioned above (e.g., the clear support of medical necessity for each individual visit). The service must not be solicited.

8. Documentation for billed visits must meet the required components of the E/M service code. Qualified E/M services health care professionals may use either the 1995 or 1997 documentation guidelines, not a combination of the two, to document a patient encounter. However, for services on or after September 10, 2013, the 1997 guidelines may be used for an extended history of present illness (HPI) along with other elements from the 1995 guidelines to document an evaluation and management service.

9. The medical record must clearly support all the criteria and provisions contained in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy. Clear documentation supporting the medical necessity of the SNF or NF visit must be maintained in the patient’s record.

10. All documentation must be maintained in the patient’s medical record and made available to the contractor upon request.

11. An advanced beneficiary notice (ABN) is required for any items or services that do not meet the threshold for a reasonable and necessary (R&N) service under Medicare. Beneficiaries should be thoroughly educated about the benefits and risks of this item or service, in addition to the financial liability. Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they do have on file an ABN signed by the beneficiary. If such notice is not given, providers may not shift financial liability for such items or services to beneficiaries after a service is denied for R&N by Medicare. The ABN must be available to the contractor when requested.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. Frequency of visits should be generally consistent with that at any other site of service for any medical problem. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Sources of Information and Basis for Decision


Evaluation and Management (E/M) tips, available at the First Coast Service Options, Inc.’s website: http://medicare.fcso.com/EM/149087.asp

## Revision History Information

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<tr>
<td>01/17/2017</td>
<td>R2</td>
<td>Revision Number: 1 Publication: January 2017 Connection LCR A/B2017002</td>
<td>Revisions Due To CPT/HCPCS Code Changes</td>
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<tr>
<td></td>
<td></td>
<td>Explanation of Revision: Based on CR9754 (October 2016 Integrated Outpatient Code Editor (I/OCE) Specifications) and CR 9749 (Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October CY 2016 Update), the LCD was revised to add HCPCS code G9685 to the “CPT/HCPCS Codes” section of the LCD. The effective date of this revision is for claims processed on or after 01/17/2017, for dates of service on or after 10/01/16.</td>
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<tr>
<td>01/01/2017</td>
<td>R1</td>
<td>Revision Number: 1 Publication: December 2016 Connection LCR A/B2017-001</td>
<td>Revisions Due To CPT/HCPCS Code Changes</td>
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<td>Explanation of Revision: Annual 2017 HCPCS Update. Revised to add HCPCS code G9685. The effective date of this revision is based on date of service.</td>
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## Associated Documents

### Attachments
Comment Summary 06/12/15-07/27/15 (a comment and response document) (PDF - 92 KB)

### Related Local Coverage Documents
LCD(s) DL36230 - (MCD Archive Site)

### Related National Coverage Documents
N/A

## Keywords
N/A