Clinical Practice Guideline: **Evaluation and Management Services in a Nursing Facility, Rest Home or Residence - Podiatry**

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GUIDELINES

American Specialty Health – Specialty (ASH) considers evaluation and management (E/M) in a nursing facility, , rest home facility or residence to be medically necessary upon meeting **ALL of the following criteria**:

A. Nursing Facility

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 they provided in the other sites of service, as well as the services they provided in the nursing facility setting.

The initial visit in a skilled nursing facility (SNF) and nursing facility (NF) must be performed by the physician. 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.

The physician may not delegate a task that the physician must personally perform. Therefore, the physician may not delegate the initial comprehensive visit in a SNF. The only exception regarding who performs the initial visit relates to the NF setting. 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.

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.

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.

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

Subsequent Nursing Facility Care

Coverage for subsequent nursing facility care for evaluation of specific medical conditions will be considered reasonable and necessary when it requires the skill of a physician 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 perform 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 specific circumstances that require the increased frequency of services with documentation of the following:

- Patient instability or change in condition that the physician documents is significant enough to require a timely medical 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, or pressure ulcer evaluation, or palliative care (for the terminally ill);
- Nursing staff, rehabilitation staff, patient, or family requests to address a documented medical issue of concern that requires a physical examination.

More frequent visits may be considered reasonable and necessary in the following clinical scenarios:

- Stage III or IV pressure sore healing;
- Management of acute exacerbation of unstable diabetes;
- Acute infection;
- Acute 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 warrant the level of care reported.

Coding Information

The principal physician of record must append the modifier "-AI" (Principal Physician of Record) to the initial nursing facility care code. This modifier will differentiate the physician who oversees the patient's care from other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation in the NF or SNF may bill the initial nursing facility care code. The initial federally mandated visit is 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. This visit must occur no later than 30 days after admission.

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.

The nursing facility services codes represent a 'per day' service. The physician may only bill for one E/M visit performed by the physician for the same patient on the same date of service.

The initial 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 require attention on the day of the mandated physician E/M visit). The physician shall bill only one E/M visit.

The CPT codes describe 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. 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.

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 are payable.

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 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).

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 their office. 'Incident to' E/M visits provided in a facility setting are not payable.

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. 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 who

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

Consultation Services

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 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.

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.
- The service was provided without face-to-face interaction with the patient.
- The medical record documentation does not clearly satisfy the 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.

B. Home or Residential Care

A Home or Residential Care visit includes a patient history, examination, problem solving and decision making at various levels of complexity, depending upon a patient's need and diagnosis. Visits may also be performed as counseling or coordination of care if medically necessary outside the office environment and are an integral part of a continuum of care. The patients seen may have chronic conditions, may be disabled, either physically or mentally, making access to a traditional office visit very difficult, or may have limited support systems. The home or residential facility visit in turn can lead to improved medical care by identification of unmet needs, coordination of treatment with appropriate referrals and potential reduction of acute exacerbations of medical conditions, resulting in less frequent trips to the hospital or emergency rooms.

Patients must understand the nature of a pre-arranged visit and consent to treatment in the home or residential facility. Payment for this type of service is based on face-to-face time with the patient alone or with the patient and family or caregiver. The work performed during that time is documented in the chart and may include direct patient assessment, care coordination, and so forth. Travel time and related expenses are not separately billable services.

It is important to note that visits to residential care facilities are expected to occur in the patient's own personal living space or a separate room dedicated for such visits. Such dedicated rooms may be substituted for the patient's own living space, are not considered a doctor's office, and may not be used as such. Any services performed in addition to the home or residential facility visit are subject to ASH clinical guideline determination.

To be reimbursable, a home or residential facility visit is provided in lieu of an office visit, ER visit or hospital visit, must meet **all of the following criteria**:

1. The service/visit must be medically reasonable and necessary and not for the convenience of the physician. The reason for a home visit in lieu of an office visit must be documented.
2. The service must be of equal quality to a similar service provided in an office. The frequency of visits required to address any given clinical problem should be dictated by medical necessity rather than site of service. It is expected that the frequency of visits for any given medical problem addressed in the home setting will not exceed that of an office setting, except on rare occasions.
3. Each visit must meet the applicable medical standards of practice.
4. The service is of such nature that it could not be provided by a visiting nurse/home health services agency under the Home Health Benefit. The E/M service will not be considered medically necessary when it is performed only to provide supervision for a visiting nurse/Home health agency visit(s).
5. A qualified physician must perform the service.
6. If the service is provided to a patient for the first time, the patient, his/her delegate, or another medical provider managing the patient's care, must request the service. The visiting provider may not directly solicit referrals. An example of inappropriate solicitation is knocking on residents' doors or placing calls to residents on the telephone to offer medical care services when there has been no referral from another professional that is already involved in the case.
7. If laboratory and diagnostic tests are performed during the course of home or residential care visits, they must meet reasonable and necessary criteria. Medical reasons for repeat testing must be clearly documented. Performance of multiple or common tests without clear evidence of medical need of the patient or changes in

the treatment regimen based on the lab tests would not be considered reasonable and necessary.

8. Any drugs and biologicals administered in the course of home or residential care visits must meet reasonable and necessary criteria. To be reimbursed as "incident to" a physician's services in the home or domiciliary setting, the drug or biological must be personally administered by the provider or under his/her personal **or** direct supervision. Coverage for the home/ residential facility services are covered only when the three key components are met and documented in the medical record. Medical necessity of the home or domiciliary E/M service is not supported when the administration of the drug or biological is the sole reason for the visit. The medical necessity criteria as outlined elsewhere in this policy must apply. Any specialized or invasive services, such as surgical procedures, physiologic monitoring, or advanced imaging performed during the course of home or residential care visits must meet reasonable and necessary criteria and must be in compliance with all applicable safety rules and quality standards.
9. Training of home or residential facility staff is not considered medically necessary.

Visits to multiple patients by the same physician of the same group may occur on the same date of service, but each service must meet the medical needs of the individual patient. Each visit must stand on its own and the medical necessity of the visit must be supported in documentation. Services provided in the home or residential facility setting must not unnecessarily duplicate services provided to the patient by other practitioners, regardless of whether those practitioners provide the service in the office, facility, or home / residential facility setting. Home /residential facility services provided for the same diagnosis, same condition, or same episode of care as services provided by other practitioners, regardless of the site of service, may constitute concurrent or duplicative care. When such visits are provided, the record must clearly document the medical necessity of such services. When documentation is lacking, the services may be considered not medically necessary.

If the total number of home and residential facilities E/M services exceeds what could reasonably be provided, based upon the applicable standard of care and the component requirements for those E/M codes, those E/M codes may be subject to medical review. For follow-up visits, the physician or that provider's medical group practice must have an ongoing patient-physician relationship with the beneficiary. Exceptions include patients who are traveling through an area and are not residents in the location where they are being seen and patients who are being seen in their homes or domiciles for urgent or episodic illness. However, the medical necessity of a home visit must be clearly documented in the medical record and the home/ residential care provider cannot solicit the visit. Examples of visit solicitation include a provider arriving without an appointment to see a patient or

seeing a patient for a scheduled, requested visit and then providing additional visits in a residential care facility to other individuals in the facility without appropriate advance requests.

The physician must be the provider of record and responsible for managing the entire disease process addressed in the visit. If the home/residential care is being provided by someone other than the provider of record and for a limited condition that would not typically prevent return to an office environment after recovery, the service will be presumed to be not medically necessary unless the provider of record requests a consultation and the care is medically necessary and clearly documented in the medical record.

The provision of services provided under the Hospice Benefit are not in the scope of this clinical guideline.

BACKGROUND AND PROVISIONS OF COVERAGE

Services will be considered medically reasonable and necessary only if performed by appropriately trained providers. This training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or should be otherwise informed by extensive continued and related medical education. If these skills have been acquired by way of continued medical education, the courses must be comprehensive and offered, sponsored, or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA), American Osteopathic Association (AOA), or American Podiatric Medical Association (APMA) as category I credit.

All diagnostic tests must be ordered by a physician who is the treating provider for the patient and who will use the test results in the patient's care. Tests not ordered by the physician who is treating the beneficiary and tests which are not used in the management of the patient's condition are not reasonable and necessary. As with any reimbursable service, to support medical necessity there must be documentation in the medical record as to why a certain modality was chosen or performed.

It is recognized that the miniaturization of electronic diagnostic testing devices is an ongoing trend that may be associated with either improved or diminished test performance. Hand-carried diagnostic equipment ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner's hand, to complex equipment systems where only a part, such as an ultrasonic probe itself, is hand-held. The appropriate assignment of a specific CPT® code to diagnostic test/equipment is not solely determined

by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. To be reimbursable, diagnostic test/equipment must meet at least these minimum criteria (this is not an all-inclusive list):

- It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
- It should be done for the same purpose that a reasonable physician would order the standard diagnostic examination.
- It must be billed using the CPT® code that accurately describes the service performed.
- The technical quality of the exam must be in keeping with accepted national standards and not require a follow-up diagnostic examination to confirm the results.
- The study must be performed and interpreted by qualified individuals.
- The medical necessity, images, findings, interpretation, and report must be documented in the medical record.

In order to be covered, use of a drug or biological agent must be safe and effective and otherwise reasonable and medically necessary. The medical reasonableness and necessity of drugs and biologicals are extensively discussed in ASH clinical guidelines. See *Hyaluronan Injections (CPG 221-S)* and *J Codes - Podiatry (CPG 238-S)* clinical practice guidelines for more detailed information.

Dosage and Frequency: Drugs or biologicals approved for marketing by the FDA are considered safe and effective when used for indications specified on the labeling. The labeling lists the safe and effective (i.e., medically reasonable, and necessary dosage and frequency). Therefore, doses and frequencies that exceed the accepted standard of recommended dosage and/or frequency as described in the package insert, are considered not medically reasonable and necessary and are therefore not reimbursable.

Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling. This statement extends to the mode of administration that is considered safe and effective by the FDA and medically reasonable and necessary by ASH criteria. Based on the above, for agents administered parenterally, the mode of administration (intramuscular, intravenous, or subcutaneous) must be in keeping with the instructions in the package insert, as approved by the FDA. If a drug is available in both oral and injectable forms and both forms are equally effective, the oral preparation shall be used, unless there is a medical reason not to do so.

Depending on a patient's condition and in situations when life threatening and other severe adverse reactions could be expected as a result of the administration of certain drugs or the

performance of specific services, the administration of the drug and performance of these services must take place in a facility equipped and staffed for cardiopulmonary resuscitation and where the patient can be closely monitored by qualified personnel for an appropriate period of time based on his or her health status. Such services performed in the home or residential facility environment without appropriate oversight, qualified staff and equipment for reasonably foreseeable complications will not be considered medically necessary.

The American Medical Association's Current Procedural Terminology (CPT®) new patient codes 99341, 99342, 99344, 99345 and established patient codes 99347-99350, for Home or Residence Services are used to report evaluation and management (E/M) services provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship).

These codes are also used when the residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility. . These CPT® codes are used to report E/M services in facilities assigned places of service (POS) codes 12 (Home), 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Facility). Assisted living facilities may also be known as adult living facilities.

Physicians 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 CPT® code range 99341-99350 to report the service they provide.

CPT® codes 99341 through 99350 . , Home/Residence E/M codes, are used to report E/M services furnished to a patient residing in a home or residence, including a private residence or temporary lodging. Short-term accommodations such as a hotel, campground, hostel, or cruise ship are including, along with an assisted living facility, group home, custodial care facility, and residential substance abuse treatment facility. The Home Services codes apply only to the specific 2-digit POS 12 (Home). Home/Residence E/Mcodes may not be used for billing E/M services provided in settings other than as described in this paragraph.

Covered services (services that are eligible for reimbursement) in the home or residence may be limited by state and/or federal regulations and by health plan guidelines and benefit coverage policies. Refer to the applicable client summary for covered services, appropriate Current Procedural Terminology (CPT) code usage, and the use of place-of-service codes. The use of these place-of-service may vary by health plan due to health plan internal claims system configuration and/or health plan benefit design. Coding instructions may differ by

health plan and may be altered during national or local disasters, during public health emergencies or during other identified events.

All services, regardless of facility type, need to be medically necessary and appropriate to the setting in which they are provided. Coverage of services, regardless of the location, is governed by the Health Plan coverage policy.

CPT® Codes and Descriptions

CPT® Code	CPT® Code Description
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

CPT® Code	CPT® Code Description
	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 comprehensive interval history; A comprehensive examination; 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. 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.
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using

CPT® Code	CPT® Code Description
	total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training, and experience. Levels of education, experience, and proficiency may

vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020)

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

References

American Medical Association. (current year). *Current Procedural Terminology (CPT) current year* (rev. ed.). Chicago: AMA

JCI. (2020). Joint Commission International Accreditation Standards for Hospitals (7th ed.): Joint Commission Resources