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

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

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

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.

All of the following criteria must be met:	**Any of the following criteria must be met:**	**Any of the following may be met:**
1. 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)). 2. 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. 3. For Survey and Certification requirements, the visit must occur no later than 30 days after admission. 4. Further, per the Long Term Care regulations at 42 CFR 483.40 (c)(4) and (e)(2), the physician may not delegate a task that the physician must personally	It would not be unreasonable for the attending physician to make several visits at the time of a **new episode of illness or an acute exacerbation of a chronic illness**. The medical record should clearly reflect the particular circumstances requiring the increased frequency of services by documenting the following: 1. 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;	1. Member is discharged from SNF/NF

perform. Therefore, the physician may not delegate the initial visit in a SNF. This also applies to the NF with one exception **Exception:** The only exception, as to who performs the initial visit, relates to the nursing facility (NF) setting. In the NF setting, a qualified non physician practitioner (NPP) such as a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS), who is not employed by the facility, may perform the initial visit when the State law permits this. The E/M visit must be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision must be met. **Exclusions:** 1. Contractors may not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a "per day" service. 2. The service was not directly provided by the physician or non-physician practitioner 3. The service was provided without face-to-face interaction with the patient. 4. The medical record documentation does not clearly satisfy the Medicare criteria for "Reasonable and Necessary". 5. The service is covered under a contract with the nursing home.	2. 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; 3. Medical conditions including delirium, dementia, or changes in mental status manifest with behavioral symptoms that require timely evaluation; and 4. 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 <u>examples</u> 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	

6. The service is a bundled part of facility services furnished to Medicare beneficiaries in the participating facility. 7. Follow-up sub specialty and/or specialized care not clearly documented in the medical record to reflect the medical necessity of the service(s) rendered. 8. Consecutive daily or courtesy visits not reasonable and necessary for follow-up. 9. The service is for non-covered screening purposes. 10. The service is not medically necessary. 11. The medical record does not verify that the service described by the CPT/HCPCS code was provided.	• Acute behavioral cognitive and/or functional changes The medical record must clearly reflect the medical necessity of the service, as well as the key components necessary to report the particular level of care reported.	