CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 808

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: JANUARY 6, 2006

Change Request 4246

SUBJECT: Nursing Facility Services (Codes 99304 - 99318)

NOTE: ***Transmittal 792, dated December 23, 2005 is rescinded and replaced with Transmittal 808, dated January 6, 2006. This instruction modifies the implementation date and adds language under BR 4246.25 that carriers do not have to adjust claims unless brought to their attention. All other information remains the same.***

I. SUMMARY OF CHANGES: This transmittal revises the Claims Processing Manual, Pub. 100-04, Chapter 12, §30.6.13 with the new code changes by the American Medical Association Current Procedural Terminology (CPT) 2006 for reporting evaluation and management visits in the skilled nursing facility (SNF) or nursing facility (NF) settings (codes 99304 - 99306 for the initial visit; codes 99307 - 99310 for subsequent nursing facility visits and code 99318 for an annual assessment visit) and who may use these codes. This transmittal identifies the federally mandated visits per the Long Term Care regulations and also clarifies the "initial visit" definition, medically necessary visits, "incident to" services, prolonged services, split/shared evaluation and management services, gang visits,and discharge day management in the SNF and NF settings.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: No later than January 23, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	12/30.6.13/ Nursing Facility Services (Codes 99304 - 99318)

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be

carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 808	Date: January 6, 2006	Change Request 4246

NOTE: ***Transmittal 792, dated December 23, 2005 is rescinded and replaced with Transmittal 808, dated January 6, 2006. This instruction modifies the implementation date and adds language under BR 4246.25 that carriers do not have to adjust claims unless brought to their attention. All other information remains the same.***

SUBJECT: Nursing Facility Services (Codes 99304 – 99318)

I. GENERAL INFORMATION

A. Background: This transmittal revises the Claims Processing Manual, Pub.100-04, Chapter 12, §30.6.13 with new code changes made by the American Medical Association (AMA) Current Procedural Terminology (CPT) 2006 for evaluation and management (E/M) visits reported in a nursing facility, beginning January 1, 2006. Payment policy is clarified for E/M visits by physicians and qualified nonphysician practitioners (NPPs). To ensure that all residents of nursing facilities have appropriate access to medical care, CMS defined "initial visit" (comprehensive assessment by the physician) per the Survey and Certification memorandum (S&C-04-08), dated November 13, 2003). Previously, NPP visits could not be paid prior to the initial visit performed by the physician in a skilled nursing facility (SNF) and in a nursing facility (NF) per Survey and Certification requirements.

B. Policy: This transmittal conveys the Medicare Part B payment policy requirements for E/M visits in these settings. NPPs may provide federally mandated visits (as permitted under the Long Term Care Regulations) and covered, medically necessary visits prior to and after the initial visit performed by the physician in the SNF and NF settings. In the NF setting, an NPP, not employed by the NF, may perform the initial visit when State law permits this and when the requirements as outlined in this transmittal are met by the NPP. The new CPT codes to begin using January 1, 2006, include the Initial Nursing Facility Care, per day, (codes 99304 – 99306), Subsequent Nursing Facility Care, per day, (codes 99307 – 99310) and Other Nursing Facility Services (code 99318 for an annual assessment). This instruction identifies when to correctly use the codes. The transmittal also addresses federally mandated and medically necessary visits, "incident to" services, prolonged services and other time-related services, split/shared E/M services, gang visits, and the SNF/NF discharge day management services. For further guidance on Survey and Certification issues refer to the Medlearn Matters article number SE0418 at www.cms.hhs.gov/medlearn/matters

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4246.1	Carriers shall instruct physicians to report the Initial Nursing Facility Care, per day (CPT codes 99304 – 99306) in a SNF and NF for an initial visit in a SNF/NF. **NOTE: Carriers shall instruct physicians and qualified NPPs regarding the information in this change request via the Medlearn Matters Article and any other viable provider outreach that the carriers deems necessary.**			X						
4246.1.1	Carriers shall instruct physicians and qualified NPPs that POS 31 (skilled nursing facility) shall be reported if the patient is in a Part A SNF stay.			X						
4246.1.2	Carriers shall instruct physicians and qualified NPPs that POS 32 (nursing facility) shall be reported 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 (no preceding 3-day hospital stay).			X						
4246.2	Carriers shall instruct physicians and qualified NPPs that only a physician may perform the initial visit in the SNF and NF settings with one exception for the NF setting as stated in Requirement 4246.4.			X						
4246.2.1	Accurate billing can be determined upon medical review when circumstances warrant. Applies to Part B contractor and is educational only for the Part A contractor.			X						
4246.3	Carriers shall instruct physicians and qualified NPPs that a qualified NPP shall meet all Medicare requirements and the E/M service shall fall within the scope of practice and licensure for the State where the service occurs.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4246.3.1	Carriers shall instruct physicians and qualified NPPs that a qualified NPP shall meet the collaboration and physician supervision requirements. A physician assistant shall meet the general physician supervision requirement.			X						
4246.4	Carriers shall instruct physicians and qualified NPPs that a qualified NPP in the NF setting (POS code 32), who is not employed by the nursing facility may perform and report the initial visit as stated in Requirements 4246.4.1 – 4246.4.3.			X						
4246.4.1	Carriers shall instruct qualified NPPs that this exception is allowed **only when State law permits this and when Requirement 4246.4.2 is met.**			X						
4246.4.2	Carriers shall instruct qualified NPPs that this exception is allowed when the **qualified NPP visit performs within the State scope of practice and licensure requirements and meets physician collaboration and physician supervision requirements for Medicare.**			X						
4246.4.3	Carriers shall instruct qualified NPPs that for this exception, the NPP shall report the CPT codes Initial Nursing Facility Care, per day, (new codes 99304 – 99306) in a NF, for the initial visit in a NF.			X						
4246.5	Carriers shall instruct physicians and qualified NPPs to follow the same guidance for performing and reporting a readmission in a SNF and NF as for the initial visit as outlined in Requirements 4246.1 through 4246.4			X						
4246.6	Carriers shall instruct physicians and qualified NPPs that federally mandated E/M visits must occur no later than 30 days after admission and at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter (refer to S&C–04-08, dated 11/13/2003).			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4246.7	Carriers shall instruct physicians and qualified NPPs, who perform federally mandated visits, and other covered and, medically necessary E/M visits, to report these E/M visits with the CPT codes, Subsequent Nursing Facility Care, per day, (new codes 99307 – 99310).			X						
4246.8	Carriers shall instruct physicians and qualified NPPs, that after the initial visit by the physician in the SNF setting, the physician may delegate alternate E/M visits to the qualified NPP (Survey and Certification requirements).			X						
4246.9	Carriers shall instruct physicians and qualified NPPs, that following the initial visit by the physician in the NF setting, NPPs, who are not employed by the NF, may perform federally mandated physician E/M visits at the option of the State (Survey and Certification requirements).			X						
4246.10	Carriers shall instruct physicians and qualified NPPs, they may not report more than one E/M visit for the same patient on the same date of service in the SNF/NF setting as the Nursing Facility Services codes represent a "per day" service.			X						
4246.10.1	Carriers shall instruct physicians and qualified NPPs that 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). Only one E/M visit shall be reported.			X						
4246.11	Carriers shall instruct physicians and qualified NPPs, that the new CPT code, Other Nursing Facility Service (99318), may be used to report an annual nursing facility assessment (E/M visit) on the required schedule of mandated visits on an annual basis.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	NOTE: Editing will be done in the Common Working File. A separate Change Request will be forthcoming with details.									
4246.11.1	Carriers shall instruct physicians and qualified NPPs that CPT code 99318 may be reported in lieu of a Subsequent Nursing Facility Care, per day, (codes 99307 – 99310) when the code requirements for 99318 are met.			X						
4246.11.2	Carriers shall instruct physicians and qualified NPPs that CPT code 99318 does not represent a new benefit service for Medicare Part B. The service represented by code 99318 shall not be performed in addition to the required number of federally mandated physician E/M visits.			X						
4246.12	Carriers shall instruct physicians and qualified NPPs to report the new CPT codes Subsequent Nursing Facility Care, per day, (99307 – 99310) for E/M visits involving medically complex care for a patient residing in a SNF following discharge from an acute care facility.			X						
4246.13	Carriers shall instruct physicians and qualified NPPs that "incident to" E/M visit requirements are confined to the discrete part of a SNF/NF designated as an office by the physician. The place of service (POS) on the claim should be "office" (POS 11).			X						
4246.13.1	Accurate billing can be determined upon medical review when circumstances warrant. Applies to Part B contractor and is educational only for the Part A contractor.	X		X						
4246.14	Carriers shall instruct physicians and qualified NPPs that E/M visits provided in an area designated as a distinct office within a SNF/NF, shall be reported using the Office or Other Outpatient CPT codes (99201 – 99215).			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4246.15	Carriers shall instruct physicians and qualified NPPs that Medicare does not pay for E/M visits that may be required by State law for a facility admission or for other E/M visits to satisfy facility or other administrative purposes.			X						
4246.16	Carriers shall instruct physicians that they have the option to bill Medicare directly or to reassign payment for his/her professional service to the facility. This is educational only for Part A contractors.	X		X						
4246.17	Carriers shall instruct physicians and qualified NPPs that NPs and clinical nurse specialists, have the option to bill Medicare directly or to reassign payment for his/her professional service to the facility, when the performance of the E/M visit by the NPP is permitted. This is educational only for Part A contractors.	X		X						
4246.18	Carriers shall instruct physicians and qualified NPPs that they shall not report Prolonged Services, (CPT codes 99354 – 99357) with the companion Nursing Facility Services codes beginning January 1, 2006. **NOTE: Typical/average time units have not been determined by the AMA for the new CPT 2006 Nursing Facility Services codes in order to permit prolonged services to be billed.**			X						
4246.18.1	Carriers shall deny Prolonged Services (CPT codes 99354 – 99357) that are billed with the Nursing Facility Services (CPT codes 99304 - 99306, 99307 – 99310 and 99318).			X						
4246.18.2	Carriers shall use the appropriate messages such as: Claim Adjustment Reason Code #152 – Payment adjusted because the payer deems the information submitted does not support this length of service; Medicare Summary Notice (MSN) # 21.21 –			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	This service was denied because Medicare only covers this service under certain circumstances; Line Item Remark #N180 – This item or service does not meet the criteria for the category under which it was billed.									
4246.19	Carriers shall instruct physicians and qualified NPPs that until typical/average time units are determined by the AMA, E/M visits for counseling/coordination of care for the 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).			X						
4246.20	Carriers shall instruct physicians and qualified NPPs that claims billed for an unreasonable number of daily E/M visits to multiple residents at a facility by the same physician within a 24-hour period may result in medical review to determine medical necessity for the visits.			X						
4246.21	Carriers shall instruct physicians and qualified NPPs that a split/shared E/M visit cannot be reported in the SNF/NF setting.	X		X						
4246.21.1	Accurate billing can be determined upon medical review when circumstances warrant. Applies to the Part B contractor and is educational only for the Part A contractor.	X		X						
4246.22	Carriers shall instruct physicians and qualified NPPs to report CPT code 99315 – 99316 (Nursing Facility Discharge Service) for an E/M visit (must be face-to-face) for discharge from the SNF/NF.			X						
4246.23	Carriers shall instruct physicians and qualified NPPs that the SNF/NF discharge shall be reported for the actual date of the E/M visit even if the patient is discharged from the facility on a different date.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4246.24	Carriers shall instruct physicians and qualified NPPs that CPT codes 99315 – 99316 (Nursing Facility Discharge Service) may be used to report a death pronouncement only if the physician or qualified NPP performed the pronouncement.			X						
4246.25	Carriers need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4246.26	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	The Survey and Certification memorandum (S&C-04-08), dated November 13, 2003 and Medlearn Matters article number SE0418 at www.cms.hhs.gov/medlearn/matters

B. Design Considerations: NA

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: NA

D. Contractor Financial Reporting /Workload Impact: NA

E. Dependencies: The American Medical Association Current Procedural Terminology (CPT) 2006 developed new codes for reporting these E/M visits in 2006. CMS is currently releasing the HCPCS tape with the new codes to be reported in 2006. The new code changes in this CR are on the HCPCS tape.

F. Testing Considerations: NA

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** No later than January 23, 2006 **Pre-Implementation Contact(s):** Kit Scally (Cathleen.Scally@cms.hhs.gov) **Post-Implementation Contact(s):** Appropriate Regional Office staff	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

30.6.13 - Nursing Facility *Services* (Codes *99304 - 99318*)

(Rev. 808, Issued:, Effective: 01-01-06, Implementation: No later than 01-23-06)

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

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 SNFs while section 1919 (b) (6) (A) of the Act governs NFs. For further information refer to Medlearn Matters article number SE0418 at www.cms.hhs.gov/medlearn/matters

The initial visit in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4)). The initial visit is defined in S&C-04-08 (see www.cms.hhs.gov/medlearn/matters) 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, a 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), the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial visit in a SNF. This also applies to the NF with one exception.

The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., 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 evaluation and management (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 (nursing facility) 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). For further guidance on POS codes and associated CPT codes refer to §30.6.14.

Effective January 1, 2006, the Initial Nursing Facility Care codes 99301– 99303 are deleted.

Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 – 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.

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial visit by the physician, 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.

Effective January 1, 2006, the Subsequent Nursing Facility Care, per day, codes 99311–99313 are deleted.

Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 – 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

Carriers 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.

Beginning January 1, 2006, the new CPT code, Other Nursing Facility Service (99318), may 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 (codes 99307 – 99310). It shall not be performed in addition to the required number of federally mandated physician visits. The new CPT annual assessment code does not represent a new benefit service for Medicare Part B physician services.

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 E/M 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.

C. Visits by Qualified Nonphysician 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. CPT codes, Subsequent Nursing Facility Care, per day (99307 - 99310), shall be reported for these E/M visits even if the visits are provided prior to the initial visit by the physician.

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 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.

D **- 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 E/M visits using the Subsequent Nursing Facility Care, per day (codes 99307 - 99310) for these E/M visits even if the visits are provided prior to the initial visit by the physician.*

E - 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.*

F - Use of the Prolonged Services Codes and Other Time-Related Services

Beginning January 1, 2006, typical/average time units for the new CPT codes for E/M visits in the SNF/NF settings have not yet been determined by the American Medical Association (AMA) and therefore, typical/average time units cannot be associated with prolonged services for E/M visits until typical/average time units are determined by the AMA. Effective January 1, 2006, the Prolonged Services (codes 99354 – 99357) may not be billed with the Nursing Facility Services (codes 99304-99306, 99307-99310 and 99318).

Counseling and Coordination of Care Visits

Until typical/average time units are determined by the AMA, E/M visits for counseling/coordination of care, for the 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).

G - Gang 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.

H - Split/Shared E/M Visit

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 consultation services, critical care services or procedures.

I – 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. The CPT codes 99315 – 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.