CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10742	**Date: May 3, 2021**
	Change Request 12275

SUBJECT: Revisions of Sections 30.6.1(B), 30.6.12, and 30.6.13(H) of Chapter 12 of the Medicare Claims Policy Manual

I. SUMMARY OF CHANGES: The purpose of this CR is to revise sections 30.6.1, 30.6.12, and 30.6.13 of the Medicare Claims Policy Manual (Internet Only Manual (IOM) Pub. 100-04) in response to a petition received in January by the U.S. Department of Health and Human Services (HHS) pursuant to the HHS Good Guidance Practices Regulation (85 Fed. Reg. 78,770 and 45 C.F.R. § 1.5(a)(1)), CMS is revising the following sections of the Centers for Medicare & Medicaid Services ("CMS") Claims Processing Manual (Pub. 100-04), Chapter 12:

- Section 30.6.1 Selection of Level of Evaluation and Management Service, (Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16); B. Selection of Level of Evaluation and Management Service; Split/Shared E/M Service.
- Section 30.6.12 Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292) (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01- 2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10), Critical Care Services (Codes 99291-99292**)**.
- Section 30.6.13 Nursing Facility Services, (Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11); H. Split/Shared E/M Visit.

CMS plans to address the topics therein through notice-and-comment rulemaking.

EFFECTIVE DATE: May 9, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 9, 2021

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	12/30/6.1/Selection of Level of Evaluation and Management Service
R	12/30/6.12/Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)
R	12/30/6.13/Nursing Facility Services

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10742	Date: May 3, 2021	Change Request: 12275

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IMPLEMENTATION DATE: May 9, 2021

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to revise sections 30.6.1(B), 30.6.12, and 30.6.13(H) of the Medicare Claims Policy Manual (Internet Only Manual (IOM) Pub. 100-04) in response to a petition received in January by the U.S. Department of Health and Human Services (HHS) pursuant to the HHS Good Guidance Practices Regulation (85 Fed. Reg. 78,770 and 45 C.F.R. § 1.5(a)(1)), CMS is revising the following sections of the Centers for Medicare & Medicaid Services ("CMS") Claims Processing Manual (Pub. 100-04), Chapter 12:

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- Section 30.6.13 Nursing Facility Services, (Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11); H. Split/Shared E/M Visit.

CMS plans to address the topics therein through notice-and-comment rulemaking.

B. Policy: HHS Good Guidance Practices Regulation (85 Fed. Reg. 78,770 and 45 C.F.R. § 1.5(a)(1))

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12275.1	Contractors shall be aware that chapter 12, sections 30.6.1(B), 30.6.12, and 30.6.13(H) are being revised in the Claims Processing Manual (IOM Pub.100-04).	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Ann Marshall, 410-786-3059 or Ann.Marshall@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

30.6.1 - Selection of Level of Evaluation and Management Service

(Rev. 10742, Issued: 05-03-21, Effective: 05-09-21, Implementation: 05-09-21)

A. Use of CPT Codes

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

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.

B. Selection of Level of Evaluation and Management Service

Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the Medicare Administrative Contractor (MAC) at the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (refer to sections 60.1, 60.2, and 60.3, chapter 15 in IOM 100-02).

SPLIT/SHARED E/M SERVICE

Left intentionally blank for future updates.

C. Selection of Level of Evaluation and Management Service Based On Duration of Coordination of Care and/or Counseling

Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete

a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

D. Use of Highest Levels of Evaluation and Management Codes

A/B MACs (B) must advise physicians that to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient's medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.

The comprehensive examination may be a complete single system exam such as cardiac, respiratory, psychiatric, or a complete multi-system examination.

30.6.12 - Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

(Rev. 10742, Issued: 05-03-21, Effective: 05-09-21, Implementation: 05-09-21)

Left intentionally blank for future updates.

30.6.13 - Nursing Facility Services

(Rev. 10742, Issued: 05-03-21, Effective: 05-09-21, Implementation: 05-09-21)

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 the Medicare Learning Network article SE0418 at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo

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-04-08 (see http://www.cms.gov/site-search/search-results.html?q=S%26C-04-08) 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, 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), in a SNF 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 federally mandated 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 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. 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 federally mandated visit. Only a physician may report these codes for an initial federally mandated 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.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial federally mandated 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 (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), 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 federally mandated 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.

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 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.

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.

A/B MACs (B) 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 federally mandated visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF and who are working in collaboration with a physician, may perform federally mandated physician visits, at the option of the State.

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 federally mandated 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. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), 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 federally mandated 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.

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 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 visits.

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 the 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, 2008, typical/average time units for E/M visits in the SNF/NF settings are reestablished. Medically necessary prolonged services for E/M visits (codes 99356 and 99357) in a SNF or NF may be billed with the Nursing Facility Services in the code ranges (99304 - 99306, 99307 - 99310 and 99318).

Counseling and Coordination of Care Visits

With the reestablishment of typical/average time units, medically necessary E/M visits for counseling and coordination of care, for Nursing Facility Services in the code ranges (99304 - 99306, 99307 - 99310 and 99318) that are time-based services, may be billed with the appropriate prolonged services codes (99356 and 99357).

G. 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.

H. Split/Shared E/M Visit

Left intentionally blank for future updates.

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.