Regulatory and Coding Compliance for APRNs in LTC Facilities and Community Settings

Valisa Saunders MN, APRN, GNP
Valisa@Hawaii.rr.com

OBJECTIVES

- Compare and Contrast State and Federal Regulatory Issues affecting APRN practice and reimbursement in LTC and Geriatrics Practices
- Identify 3 areas of LTC regulations that are issues in clinical practice in LTC and geriatrics practices

Regulatory and Coding Compliance

- Correctly Identify Common Procedural Technology (CPT) & Place of Service (POS) codes effective Jan 1, 2006 for the following locations; skilled nursing facilities, nursing facilities, domiciliary, assisted living, home, and group homes.
Regulatory and Coding Compliance

OBJECTIVES

- List essential components of Medicare documentation needed to bill for initial, subsequent and annual assessment CPT codes
- Describe two key components to meet criteria for “medical necessity” under Medicare guidelines

Regulatory and Coding Compliance

OBJECTIVES

- Identify Center for Medicare and Medicaid Services (CMS) and other websites to find key information for bill submission requirements

History of Medicare & Nurse Practitioners

- 1965 - Social Security Act authorized Medicare program
- OBRA 1987-recognized NP/CNS/PA for first time in long term care
- BBA 1997- authorized direct reimbursement to advanced practice nurses by Medicare (Part B)
- DIMA 2003-Medicare Drug Prescription Improvement & Modernization Act
Omnibus Reconciliation Act, 1987 (OBRA, ’87)

- Nursing Home Reform
- Authorized NP/CNS/PA for LTC visits
- Provided indirect reimbursement to APNs in LTC (OBRA, 1989)

OBRA, 1987 addressed:

- Residents' Rights
- Restraint Use
- Unnecessary Medication Use (Psychotropic drugs)
- Drug Regimen Reviews
- Pre-admission screening for Serious Mental Illness (SMI)

Balanced Budget Act, (BBA) 1997

- Cut payments to Home Health Care
- PPS/RUGS Payment system for LTC
- Direct Reimbursement to APNs for Medicare part B services
- Removed site restrictions for APNs
- Quality Indicators
Medicare Modernization Act of 2003 (DIMA or MMA)

- Allows NP to be Hospice “Attending”
- Encouraged Demonstration Projects
- Adult Day Care Demonstration Programs

MEDICARE ALPHABET DECODING

A = Inpatient Hospital Stay, Skilled Nursing/Rehabilitation Facility stay (up to 100 days), Some Home Health Agency Services and Hospice Benefits
B = Medically necessary services by MD/APRN (etc), and many other services and supplies, Durable Medical equipment and some vaccines

MEDICARE ALPHABET DECODING

C = Persons with Medicare Part A & B can choose to receive all of their health care services through one provider organization. (Medicare choice)
D = Prescription drug coverage (Part D) that helps pay for medications providers prescribe for treatment. Includes Zostavax vaccine.

Source: http://www.ssa.gov/pubs/10043.html
### SNF VS NF
- SNF = On Medicare Benefits (up to 100 days per spell of illness for payment to the facility (Place of Service code 31)
- NF = NOT on Medicare Benefits regardless of level of care (POS 32)
- This is important to know in determining what the NP can or cannot do in their role with a particular patient in LTC
- Selection of level of service/coding is not affected by Coverage for SNF vs NF

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### Regulatory Overview:

#### Basic Premises
- You can’t do anything that is not in your scope of practice.
- You can’t do everything that is in your scope of practice in the real world.
- You can’t bill for anything not in your scope of practice.
- You can’t bill Medicare for anything CMS doesn’t authorize you to do, and you must be authorized by your state.

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### Regulatory Overview:

#### Basic Premises
- Facility/Employer policies, privileging or job descriptions may further limit scope, but cannot expand it beyond state or federal authorization
- External certifying agencies impact scope of practice in workplace settings (JAHCO, NCQA, CMS, etc)
Regulatory Overview: Basic Premises

- CMS regulations are not always logical
- CMS regulations are the law
- Coders don’t always know about regulations affecting Nurse Practitioner scope of practice
- MDs don’t always know about regulations affecting Nurse Practitioner scope of practice

Regulatory Overview
APRN function affected by;

- STATE Licensing Laws for Long Term Care, Assisted Living, Foster Care etc
- Scope of Practice-State Board of Nursing, Employer or other Credentialing and privileging bodies (eg outside LTC facilities, insurance agencies)
- Job descriptions
- Practice acts of other health care team members in your state (OT, PT, ST, RD)

*formerly HCFA

Regulatory Overview
APRN function affected by;

- FEDERAL Regulation of Medicare certified Skilled Nursing Facilities (SNFs) & Nursing Facilities (NFs)- Administered by Centers for Medicare and Medicaid Services (CMS)* 42 CFR 483.40
- The Social Security Act (§ 1819 (b) (6) (A) ) governs SNFs while § 1919 (b) (6) (A) governs NFs.

*formerly HCFA
Regulatory Overview
APRN function affected by:
- Transmittal 1690 outlines SNF/LTC facility care issues for all providers
- Transmittal 1734 outlines rules for reimbursement to APRNs
- The CMS letter of November 13, 2003 reviews the roles of APRNs in LTC Facilities/SNFs in narrative and a table.
- Medlearn matters article SE0418 also reviews the issues pertinent to APRNs working in LTC facilities.

Regulatory Overview
Importance
- Local Surveyors may not know or understand role or scope of practice issues
- State Licensing regulations may conflict with federal rules or be silent
- Fiscal Intermediaries may not know regulations related to APRNs and may penalize facilities
- Facilities may make their own policies/determinations

What the APRN can never do:
- “Initial” Skilled Nursing Facility visit and plan of care that must be done by MD.
- Alternate required SNF visits that must be done by MD (can do alternate required visits after “Initial”)
- Ordering of Home Health, Initial plan of care and 60 day recertification
- Terminal Certification Determination for Hospice patients and initial plan of care
What the APRN CAN do:

- “Initial” Nursing Facility (NF) visit and plan of care and all NF required visits IF in “waiver” state, and not employed by facility
- Alternate required SNF visits after “Initial” by MD
- Any medically necessary visit in LTC, at home or for Hospice patient.
- Care plan oversight for Home Health **
- Be Hospice “Attending” on election (NP only)

What the LTC Facility employed APRN can never do:

- “Initial” Skilled Nursing Facility visit and plan of care that must be done by MD
- Alternate required SNF visits that must be done by MD (can do alternate required visits after “Initial”)
- Any required visit for Nursing Facility (NF) patients
- Any Medicare SNF post-hospital care certification or recertification.

What the LTC Facility employed APRN CAN do:

- Alternate required SNF visits that must be done by MD (can do alternate required visits after “Initial”)
- Any medically necessary visit for SNF or NF patient.
Reimbursement Issues

- Correct Credentials
- Active NPI (Effective May 22, 2007).
- Replaced PIN
- APRN receives 85% of physician rate or 80% of actual charges, whichever is lesser
- [www.cms.hhs.gov/MLNProducts/70_AP NPA.asp](http://www.cms.hhs.gov/MLNProducts/70_AP NPA.asp)

*Site information and organization is periodically updated or changed.*

Reimbursement Issues

- NPP must accept the assignment
- Based on Coding
- Coding Determined by Selection of CPT/Level of service codes and appropriate ICD-9 codes
- Must be qualified to provide the service in your state and consistent with federal regulations, and not excluded from coverage
- Medicare is our primary frame of reference, but not the only insurer

Reimbursement Issues

- Prolonged Service Codes for LTC settings became effective July 1, 2008 because time standards for the January 2006 CPT codes were finally established.
- The Prolonged Service Codes are for all settings, CPT codes 99354-99359 in CMS Transmittal 1490 (4.11.08) at:
Reimbursement Issues

- Exclusions from coverage: Routine foot care, routine physical exams and services that are not reasonable and necessary for the diagnoses or treatment of an illness or injury to improve the functioning of a malformed body member
- "Incident to" billing not allowed in LTC
- "Incident to" services can be applied to APN

SEE TRANMITTAL 1690 SECTION 15509.1

Coding Issues

- AMA owns CPT codes
- Federal government owns ICD-9 codes
- Coding Based on Documentation
- Face to face visit with exam required
- MEDICAL NECESSITY is the essential component for a billable encounter.
- Required LTC facility visits are the exception
- Medicare does not pay for State or other agency “requirements”

Coding Issues: Medical Necessity

- Defined in SSA 1862(a)(1)(A)- Services paid for by Medicare must be reasonable and necessary for diagnosis or treatment of an illness or injury
- Services that would ordinarily be provided by a physician
- Need chief complaint
Coding Issues:
Place of Service Codes (POS)
- Affects payment level
- Affects cluster of CPT codes used
- See Table I for LTC place of service codes (31=SNF), (32=NF)
- See Table II for Community LTC place of service codes (Domiciliary=33, Group Home=14, Assisted Living=13, Home=12)

Coding Issues:
Common Procedural Terminology (CPT)
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- Affects cluster of CPT codes used
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Nursing Facility Services
CPT codes
Initial NF Visit
- 99304  Level Low
- 99305  Level Moderate
- 99306  Level High
Subsequent NF Visit
- 99307  Level 1
- 99308  Level 2
- 99309  Level 3
- 99310  Level 4
Annual Assessment
- 99318

Discharge codes
- 99315 (< 30 minutes)
- 99316 (> 30 minutes or more)

Consult; Opinion or Advice
- 99251  Level 1
- 99252  Level 2
- 99253  Level 3
- 99254  Level 4
- 99255  Level 5
Home Services CPT codes

New Patient Visit
- 99341 Level 1
- 99342 Level 2
- 99343 Level 3
- 99344 Level 4
- 99345 Level 5

Established Visit
- 99347 Level 1
- 99348 Level 2
- 99349 Level 3
- 99350 Level 4

Care Plan oversight
- 99399 15-29 minutes within calendar month
- 99340 30 minutes or more

Domiciliary Services* CPT Codes

New Patient Visit
- 99324 Level 1
- 99325 Level 2
- 99326 Level 3
- 99327 Level 4
- 99328 Level 5

Established Patient Visit
- 99334 Level 1
- 99335 Level 2
- 99336 Level 3
- 99337 Level 4

Care Plan Oversight
- 99339 15-29 minutes within a calendar month
- 99340 30 minutes or more

*Use Same CPT codes for Domiciliary, Assisted Living and Group/Carehomes, place of service codes 13,14 and 33

Long Term Care Regulations: Physician Services- 483.40

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. (guidelines note that admission orders will be accepted as “personal approval” of the admission).

CFR 42.483.40 or Survey Protocol
Long Term Care Regulations: Physician Services- 483.40 (a)

(a) Physician Supervision

The facility must ensure that:
(1) the medical care of each resident is supervised by a physician (483.40 (a) (1)) and
(2) Another physician supervises the medical care of residents when their attending physician is unavailable. (42 CFR 483.40(a))

Long Term Care Regulations: Physician Services- 483.40 (b)

(b) Physician Visits

The physician must:
(1) Review the resident’s total program of care, including medications and treatments, at each visit required by paragraph (c) of this section:
(2) Write, sign, and date progress notes at each visit; and
(3) Sign and date all orders

Long Term Care Regulations: Physician Services- 483.40(c)

(c) Frequency of physician visits

“Required Visit Schedule” is at 30-60-90 days after admission, then every 60 days.
(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.
(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
Long Term Care Regulations: Physician Services- 483.40(c)

(3) Except as provided in paragraphs (c) (4) & (f) of this section, all required physician visits must be made by the physician personally.

(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist, in accordance with paragraph (e) of this section.

Long Term Care Regulations: Physician Services- 483.40(d)

(d) Availability of physicians for emergency care: The facility must provide or arrange for physician services 24 hours a day in case of emergency.

Long Term Care Regulations: Physician Services- 483.40(e)

(e) Physician delegation of tasks in SNFs

(1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who
Long Term Care Regulations:
Physician Services- 483.40(e)

….to a PA, NP or CNS who:
(i) meets the applicable definition in 491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State:
(ii) is acting within the scope of practice as defined by state law and
(iii) is under the supervision of the physician.

Long Term Care Regulations:
Physician Services- 483.40(e)

(2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

Long Term Care Regulations:
Physician Services- 483.40 (f)

(f) Performance of physician tasks in NFs
At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.
COLLABORATION
As Defined by CMS

Collaboration is a process in which a NP works with one or more MD (or DO) to deliver health services with medical direction and appropriate supervision as required by the law of the state in which the services are furnished. In the absence of State Law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.

CMS MEMO of 11.13.03

Revised from earlier in 2003
Interprets CFR 42 483.40 in table form and text
Clarifies restrictions on Employed APNs and PA.
Clarified issue of certifications
Clarified co-signatures on orders

Clinical Issues in LTC
Role Issues

Service Model – MD vs. NP roles
Primary Care Provider
Required Visits
Episodic Care
Annual Exams
Discharge Planning
Advance Directive Planning
After hours Service/Calls
Clinical Issues in LTC
Regulatory Driven

- Timely Care
- Use of Restraints (facility driven)
- Use of Psychotropic and other unnecessary drugs
- Mental Health Issues (diagnosis and treatment and PASAR requirements)
- Quality Indicators

Use of Psychotropic Drugs

- Chemical Restraints?
- Be clear on target behaviors
- Demand documentation & non-pharmacological interventions
- Is it psychosis?
- Treat underlying, infections, pain and depression

Use of Unnecessary Drugs

- Based on the Beers List
- Be aware of FDA warning on “off-label” use of antipsychotics
- Includes excessive dose, duration, inadequate documentation for use…
- Specific list found in LTC Survey
Clinical Issues in LTC
Drug Regimen Review

- Pharmacist Review required every 30 days
- Drugs to Avoid originated from “Beers” List
- High Risk drugs needing monitoring
- Psychotropic drug use
- Duplicate Therapy

Clinical Issues in LTC
Mental Illness Screening

- Pre-admission Screening Annual Resident Review (PASARR)
- Level I Screen must be done prior to admission
- If Criteria for Serious Mental Illness (SMI) met, may need a Level II (psychiatric evaluation)
- Have Psychoactive drugs been prescribed on a regular basis within the last two years?
- Psychosis of Dementia not included

Clinical Issues in LTC
Quality Indicators

$SENTINEL EVENTS

- Fecal Impaction
- Dehydration
- Pressure Ulcers in low risk patient
Clinical Issues in LTC
Quality Indicators

Clinical Drug Management
- Use of 9 or more different medications
- Relevance to falls, fecal impaction, weight loss, cognitive changes, behavioral disturbances or ADL decline
- Use of psychotropic drugs, antianxiety and hypnotic drug use

Clinical & Quality Issues in LTC
APN Contributions
- Timely follow up on problems and attention to quality indicators
- Timely required visits
- Compliance with regulations related to physical and chemical restraints, "unnecessary drugs," drug regimen review and mental health problems
- Monitoring of appropriate rehabilitation therapies

Contributions in LTC – To Do
- Senate Bill (S. 1678), the Home Health Care Planning and Improvement Act
  - Introduced in late June, 2007
  - Would authorize Medicare (CMS) to allow Advanced Practice Nurses - NPs, CNS and CNMs to order, certify home health services and sign home health plans of care.
- LTC Quality and Modernization Act (pulled in 2007)
Coding for Compliance Documentation:

Areas that determine levels of E/M services

- History
- Exam
- Medical Decision Making (MDM)
- Counseling
- Coordination of Care
- Nature of the presenting problem and
- Time

Documentation:
Three Key components

- History
- Exam
- Medical Decision Making (MDM)
Documentation:
Chief Complaint
- Usually in the patient’s own words – more likely the staff in LTC, or family members for many geriatric patients
- Include duration
- Don’t use “routine”
- May use “follow up for…”
- May use “Required” 60 day visit in LTC

Documentation:
History of Present Illness
- Location
- Onset
- Duration
- Quality
- Severity
- Timing
- Context
- Modifying Factors
- Associated signs or symptoms
- OR STATUS OF 3 OR MORE CHRONIC CONDITIONS

Documentation:
Review of Systems (symptoms)
- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin
- Neurological
- Psychiatric
- Endocrine
- Hem/lymph
- All/immunologic
- “All others reviewed & negative”
Documentation: PMFSH

- **Past Medical History** (illnesses, operations, injuries, treatments, allergies, current medications)
- **Family History** (Health status or cause of death of parents, siblings and children, specific disease(s) related to the chief complaint)
- **Social History** (Age appropriate review of past and current activities; living arrangements, marital status, current employment, use of drug, alcohol and tobacco, level of education, sexual history or other relevant social factors)

Documentation: History – Putting it together

<table>
<thead>
<tr>
<th></th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI</td>
<td>Brief 1-3</td>
<td>Brief 1-3</td>
<td>Extended 4 or more</td>
<td>Extended 4 or more</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Pertinent to problem (1 system)</td>
<td>Extended 2-9</td>
<td>10 or more</td>
</tr>
<tr>
<td>PMFSH</td>
<td>None</td>
<td>None</td>
<td>Pertinent 1 area</td>
<td>3 for New Pt., Consulta, ER, Admissions</td>
</tr>
</tbody>
</table>

Documentation: THE EXAMINATION

- Body Areas
- Organ Systems
- Constitutional Symptoms
THE EXAMINATION: Body Areas

- Head including the face
- Neck
- Chest, including the breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

THE EXAMINATION: Organ Systems

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integument
- Neurological
- Psychiatric
- Endocrine
- Hem/lymph
- All/immunologic
- “All others negative”

EXAMINATION:

- Constitutional Signs
  - Appearance
  - Fever
  - Weight Loss
  - Growth and development
### Documentation: EXAM – Putting it together

<table>
<thead>
<tr>
<th>Body Areas</th>
<th>Organ systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Limited exam of affected body area or organ system (1-5 elements)</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Limited exam &amp; other symptomatic or related organ systems (6 elements in 1 or more body/organ systems)</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended exam &amp; other symptomatic or related organ systems (6 areas or 12 pts in &gt; two in detail)</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>8 or more organ systems (don’t mix body/organ systems at this level)</td>
</tr>
</tbody>
</table>

### Documentation: Medical Decision Making (MDM)

Complexity Determined by:
- The number of possible diagnoses, and/or the number of management options that must be considered, complexity of the data reviewed or ordered, and risk.
- Two of these three elements must either meet or exceed the requirement for the level selected (low, moderate, or highly complex).

<table>
<thead>
<tr>
<th>TYPE DECISION MAKING</th>
<th>No. of Dx or Management options</th>
<th>Amt and/or complexity of the data to be reviewed</th>
<th>Risk of significant complications, morbidity/mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

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Important Regulatory References

- www.cms.hhs.gov (Center for Medicare and Medicaid Services)
- www.cms.hhs.gov/CFCsAndCoPs (Conditions of Participation (COPS) and Conditions for Coverage (CICs): Go to LTC Facilities “current conditions” 42 CFR 483.1-483.75 for LTC survey- 483.40 for physician services)

Important Regulatory References

- www.ascp.com/public/pr/hcfares.shtml (web page for American Society of Consultant Pharmacists – has links to MDS and LTC survey information
- www.ascp.com/public/pr/may_hcfa_PDFs.shtml (Nursing Facility Briefing Rm. Includes survey and quality indicator issues)
- ACOVE indicators: www.rand.org/health/projects/acove/acove2/

Important Regulatory References

- www.cms.hhs.gov/mlnmattersarticles/ (Physician fee schedules, manuals, regulations, documentation guidelines for evaluation and management services, Request CD ROMs & videos, ICD –9 codes information, join list-serve
- www.access.gpo.gov/nara/cfr/waisidx_01/42 cfr483_01.html - LTC survey pdf files by section
Medicare Provider Recognition Requirements for APRNs

- Meet all state requirements as APRN
- Be certified as an APRN by a recognized national certifying body that has established standards for APRNs or
- Meet state requirements and have been granted PIN as NP by 12-31-2000
- Masters degree requirement added in addition to above as of 1-01-2003.

Revised 42 C.F.R. 410.75(b) & makes conforming changes to 485.705(e)(1).

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■ Describe two key components to meet criteria for “medical necessity” under Medicare guidelines

Regulatory and Coding Compliance

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■ Identify Center for Medicare and Medicaid Services (CMS) and other websites to find key information for bill submission requirements
## Table II
New CPT codes Effective January 1, 2006 for Assisted Living, Domiciliary, Rest Home, Custodial Care Services, and Care Plan oversight.
And comparison with current codes for Medical Home Visits

<table>
<thead>
<tr>
<th>Domiciliary/ Rest Home/ Custodial</th>
<th>Group/Care-Home</th>
<th>Assisted Living</th>
<th>Home</th>
<th>Coding Requirements</th>
<th>Element Requirements</th>
<th>Typical Time Factors for Domiciliary, Rest Home, Group Home</th>
<th>Time factors for Medical Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>POS 33</td>
<td>POS 14</td>
<td>POS 13</td>
<td>POS 12</td>
<td>INITIAL VISITS require 3/3 Key Elements of History, Exam and Medical Decision Making (MDM)</td>
<td></td>
<td>Includes counseling and/or coordination of care with other providers or agencies consistent w the nature of problem and pt. and/or family’s needs.</td>
<td></td>
</tr>
<tr>
<td><strong>INITIAL VISIT CODES</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>99324</td>
<td>99341</td>
<td></td>
<td></td>
<td>Problem focused history</td>
<td>Problem focused exam</td>
<td>1-3 HPI, 1 exam</td>
<td>20 min face to face time with patient and/or family or caregiver</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Problem focused exam MDM Straightforward</td>
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</tr>
<tr>
<td>99325</td>
<td>99342</td>
<td></td>
<td></td>
<td>Expand problem focus history</td>
<td>Expand problem focused exam</td>
<td>1-3 HPI, 1 ROS/2-7 exam</td>
<td>30 min face to face time with patient and/or family or caregiver</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Expand problem focused exam MDM low complexity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99326</td>
<td>99343</td>
<td></td>
<td></td>
<td>Detailed history</td>
<td>Detailed exam</td>
<td>4 HPI, 2-9 ROS, 1 PFSH, 2-7with 1 detailed exam</td>
<td>45 min face to face time with patient and/or family or caregiver</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Detailed exam MDM moderate complexity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99327</td>
<td>99344</td>
<td></td>
<td></td>
<td>Comprehensive history</td>
<td>Comprehensive exam</td>
<td>4 HPI, 10 ROS, 2PFSH, 8 sys exam</td>
<td>60 min face to face time with patient and/or family or caregiver</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Comprehensive exam MDM moderate complexity</td>
<td></td>
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<td>99328</td>
<td>99345</td>
<td></td>
<td></td>
<td>Comprehensive history</td>
<td>Comprehensive exam</td>
<td>4 HPI, 10 ROS,2PFSH, 8 sys exam</td>
<td>75 min face to face time with patient and/or family or caregiver</td>
</tr>
<tr>
<td></td>
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<td>Comprehensive exam MDM high complexity</td>
<td></td>
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<tr>
<td>Domiciliary/Rest Home/ Custodial POS 33</td>
<td>Group/Care Home POS 14</td>
<td>Assisted Living POS 13</td>
<td>Home POS 12</td>
<td>Coding Requirements</td>
<td>Element Requirements</td>
<td>Typical Time Factors for Domiciliary, Rest Home</td>
<td>Time factors for Medical Home Visits</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
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</tr>
</tbody>
</table>

**SUBSEQUENT VISIT CODES**

Requires 2/3 key elements at the level of coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Description</th>
<th>Time Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>99334</td>
<td>99347</td>
<td>Problem focused interval history Problem focused exam MDM straightforward</td>
<td>1-3 HPI, 1 exam</td>
</tr>
<tr>
<td>99335</td>
<td>99348</td>
<td>Expanded problem focused interval history Expanded problem focused exam MDM low complexity</td>
<td>1-3 HPI, 1 ROS/2-7 exam</td>
</tr>
<tr>
<td>99336</td>
<td>99349</td>
<td>Detailed interval history Detailed exam MDM moderate complexity</td>
<td>4 HPI, 2-9 ROS, 1 PFSH, 2-7 with 1 detailed exam</td>
</tr>
<tr>
<td>99337</td>
<td>99350</td>
<td>Comprehensive interval history Comprehensive exam MDM mod-high complexity</td>
<td>4 HPI, 2-9 ROS, 1 PFSH, 2-7 with 1 detailed exam</td>
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</tbody>
</table>

**CARE PLAN OVERSIGHT CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Description</th>
<th>Time Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>99339</td>
<td>99339</td>
<td>These codes are for patients not in nursing homes, Hospice, or Home Health Services. These are new codes for services not previously covered by Medicare. Relative Value Update Committee (RUC), has not been published yet.</td>
<td>15-29 minutes within calendar month</td>
</tr>
<tr>
<td>99340</td>
<td>99340</td>
<td>Medicare. Relative Value Update Committee (RUC), has not been published yet.</td>
<td>30 minutes or more within calendar month</td>
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</table>

<table>
<thead>
<tr>
<th>Place</th>
<th>SNF</th>
<th>NF</th>
<th>Coding Requirements</th>
<th>Element Requirements</th>
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<tbody>
<tr>
<td><strong>INITIAL VISIT CODES</strong></td>
<td></td>
<td></td>
<td>INITIAL VISITS &amp; ANNUAL ASSESSMENT require</td>
<td>3/3 Key Elements of History, Exam and Medical Decision Making (MDM)</td>
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<tr>
<td>Typical time spent</td>
<td>POS 31</td>
<td>POS 32</td>
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<tr>
<td>25 minutes</td>
<td>99304</td>
<td>99304</td>
<td>Detailed or comprehensive history</td>
<td>4 HPI, 2-9 ROS, 1 PFSH, 2-7 w/1 detailed exam</td>
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<td>Detailed or comprehensive exam</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>MDM straightforward or low complexity</td>
<td></td>
</tr>
<tr>
<td>35 minutes</td>
<td>99305</td>
<td>99305</td>
<td>Comprehensive history</td>
<td>4 HPI, 10 ROS, 2 PFSH, 8Sys Exam,</td>
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<td></td>
<td></td>
<td></td>
<td>Comprehensive exam</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MDM of moderate complexity</td>
<td></td>
</tr>
<tr>
<td>45 minutes</td>
<td>99306</td>
<td>99306</td>
<td>Comprehensive history</td>
<td>4 HPI, 10 ROS, 2 PFSH, 8Sys Exam,</td>
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<td></td>
<td></td>
<td></td>
<td>Comprehensive exam</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MDM of high complexity</td>
<td></td>
</tr>
<tr>
<td><strong>SUBSEQUENT VISITS</strong></td>
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<td>Requires 2/3 key elements at the level of coding</td>
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<tr>
<td>10 minutes</td>
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<td>1-3 HPI, 1 Exam</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Problem focused exam</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MDM straightforward</td>
<td></td>
</tr>
<tr>
<td>15 minutes</td>
<td>99308</td>
<td>99308</td>
<td>Expanded problem focused interval history</td>
<td>1-3 HPI, 1 ROS, 2-7 Exam</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Expanded problem focused exam</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MDM low complexity</td>
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<tr>
<td>25 minutes</td>
<td>99309</td>
<td>99309</td>
<td>Detailed interval history</td>
<td>4 HPI, 2-9 ROS, 1PFSH, 2-7w 1 detailed Exam</td>
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<tr>
<td></td>
<td></td>
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<td>Detailed exam</td>
<td></td>
</tr>
<tr>
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<td>MDM moderate complexity</td>
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<tr>
<td>35 minutes</td>
<td>99310</td>
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<td>Comprehensive interval History</td>
<td>4 HPI, 10 ROS, 2PFSH, 8 sys Exam</td>
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<td>Comprehensive Exam</td>
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</tr>
<tr>
<td></td>
<td></td>
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<td>MDM moderate or high complexity</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Discharge &lt; 30 minutes</td>
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<td>99315</td>
<td>Discharge day management, including death pronouncement &lt; 30 minutes</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Discharge &gt; 30 minutes</td>
<td>99316</td>
<td>99316</td>
<td>Discharge Day Management, including death pronouncements &gt; 30 minutes</td>
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<td>ANNUAL NURSING FACILITY ASSESSMENT 30 minutes</td>
<td>99318</td>
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<td>Detailed interval history</td>
<td>4 HPI, 2-9 ROS, 1 PFSH, 8sysExam,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Comprehensive exam</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MDM low or moderate complexity</td>
<td></td>
</tr>
</tbody>
</table>

DATE: November 13, 2003

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)

The purpose of this memorandum is to clarify for State survey agencies and providers the regulatory differences concerning physician delegation of tasks in SNFs and NFs. The distinction in policies between these two settings (SNFs and NFs) is based in statute. Inaccurate interpretation of these regulations may affect compliance and may also affect payment to providers. The key to accurate interpretation is identifying what setting, SNF or NF, the physician services are being provided. Table 1, which summarizes these delegations, is provided at the end. This memorandum addresses the issue of the authority of physician extenders to: 1) perform physician visits and write orders; and 2) sign certifications and re-certifications in SNFs and NFs.

This memorandum replaces Survey and Certification memorandum S&C-03-18 dated April 10, 2003, which discusses physician delegation of tasks in SNFs and NFs. Please disregard the April 10 version.

Physician Delegation of Tasks in Skilled Nursing Facilities.

Under the requirements for long term care facilities, the regulations at 42 C.F.R. 483.40(e) state that, “A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.”

Physician and other Medically Necessary Visits in SNFs: The initial comprehensive visit in a SNF is the initial visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident. Under the regulations at 42 C.F.R. 483.40(c)(1), the initial comprehensive visit must occur no later than 30 days after admission. Further, under 42 C.F.R. 483.40(c)(4) and (e), the physician may not delegate the initial comprehensive visit in a SNF. Non-physician practitioners may perform other medically necessary visits prior to and after the physician initial comprehensive visit.
Once the physician has completed the initial comprehensive visit in the SNF, the physician may then delegate alternate visits to a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) who is licensed as such by the State and performing within the scope of practice in that State, as required under 42 C.F.R. 483.40(c)(4).

Certifications/Re-certifications in SNFs: Under the SNF regulations at 42 C.F.R. 424.20, certifications and re-certifications are required to verify that a resident requires daily skilled nursing care or rehabilitation services. 42 C.F.R. 424.20(e)(2) (which reflects the requirements of the law at section 1814 (a)(2) of the Social Security Act) states that NPs and CNSs who are not employed by the facility and are working in collaboration with a physician, when permitted under the scope of practice for the State, may sign the required initial certification and re-certifications. By contrast, PAs (regardless of employment) and those NPs and CNSs who are employed by the facility do not have authority to sign initial certifications or the SNF required recertifications.

Performance of Physician Tasks in Nursing Facilities.

Physician and Other Medically Necessary Visits in NFs: The initial comprehensive visit in a NF is the same as in a SNF. That is, the initial comprehensive visit is the initial visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident, which must take place no later than 30 days after admission. The regulations at 42 C.F.R. 483.40(f) state that “At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.” In other words, non-physician practitioners that have a direct relationship with a physician and who are not employed by the facility may perform the initial comprehensive visit, any other required physician visit and other medically necessary visits for a resident of a NF as the State allows. Non-physician practitioners may also perform other medically necessary visits prior to and after the physician initial comprehensive visit.

At the option of the State, NPs, PAs, and CNSs who are employees of the facility, while not permitted to perform visits required under the schedule prescribed at 42 C.F.R. 483.40(c)(1), are permitted to perform other medically necessary visits and write orders based on these visits. The physician must verify and sign any orders written by non-physician practitioners who are employed by the facility. For example, if a resident complains of a headache, the NP, CNS, or PA employed by the facility may assess the resident and write orders to address the condition. The physician must then verify and sign the orders. However, these medically necessary visits performed by NPs, CNSs, and PAs employed by the facility may not take the place of the physician required visits, nor may the visit count towards meeting the required physician visit schedule prescribed at 42 C.F.R. 483.40(c)(1).

Dually Certified Facilities.

While the CFR does not address dually certified SNF/NFs directly, the CFR is clear about who can perform tasks in a SNF and in a NF. In a facility where beds are dually certified, the facility must determine how the resident stay is being paid. For residents in a Part A Medicare stay, the PA, NP, and CNS must follow the guidelines for services in a SNF.
For Medicaid stays, the PA, NP, and CNS must follow the provisions outlined for care in NFs. As such, in a dually certified nursing home, any required physician task for a Medicaid beneficiary in a NF certified bed, at the option of the State, may be performed by a NP, CNS, or PA who is not an employee of the facility but who is working in collaboration with a physician. In addition, in a dually certified nursing home and at the option of a physician, required physician visits for a Medicare beneficiary in a SNF certified bed may be alternated between personal visits by the physician and visits by a PA, CNS, or NP after the physician makes the initial first visit.

Table 1 below summarizes the requirements for non-physician practitioners to perform visits, sign orders, and sign certifications and recertifications, when this function is permitted under the scope of practice for the State.

Table 1: Authority for Non-physician Practitioners to Perform Visits, Sign Orders and Sign Certifications/Recertifications When Permitted by the State*

<table>
<thead>
<tr>
<th></th>
<th>Initial Comprehensive Visit /Orders</th>
<th>Other Required Visits^</th>
<th>Other Medically Necessary Visits &amp; Orders+</th>
<th>Certification/ Recertification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SNFs</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>NP &amp; CNS employed by the facility</td>
<td>May not perform/ May not sign</td>
<td>May perform</td>
<td>May perform and sign</td>
<td>May not sign</td>
</tr>
<tr>
<td>NP &amp; CNS not a facility employee</td>
<td>May not perform/ May not sign</td>
<td>May perform</td>
<td>May perform and sign</td>
<td>May sign subject to State Requirements</td>
</tr>
<tr>
<td>PA regardless of employer</td>
<td>May not perform/ May not sign</td>
<td>May perform</td>
<td>May perform and sign</td>
<td>May not sign</td>
</tr>
<tr>
<td><strong>NFs</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NP, CNS &amp; PA employed by the facility</td>
<td>May not perform/ May not sign</td>
<td>May not perform</td>
<td>May perform and sign</td>
<td>May sign subject to State Requirements</td>
</tr>
<tr>
<td>NP, CNS &amp; PA not a facility employee</td>
<td>May perform/ May sign</td>
<td>May perform</td>
<td>May perform and sign</td>
<td>May sign subject to State Requirements</td>
</tr>
</tbody>
</table>

*This reflects clinical practice guidelines

^Other required visits are the required monthly visits that may be alternated between physician and non-physician practitioner after the initial comprehensive visit is completed

+Medically necessary visits may be performed prior to the initial comprehensive visit
Effective Date: This policy is in effect immediately.

Training: This policy should be shared with all appropriate survey and certification staff, their managers, and the state/regional office training coordinator.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)