TITLE: Nursing Facility E/M Services and the Use of Advanced Practice Professionals

POLICY/PURPOSE:

This policy and procedure applies to physicians, UF or UFJPI employed Advanced Practice Professionals ("APPs"), namely Advanced Practice Registered Nurses ("APRNs"), Clinical Nurse Specialists ("CNSs"), and Physician Assistants ("PAs"). This policy and procedure stipulates when certain nursing facility E/M services may be billed and by whom. Inherent in this policy and procedure is the underlying premise that the documentation supports the appropriate service billed and that the APP providing the service is compliant with state scope of practice requirements.

Note: Refer to Policy # PB-06-01-001 (Nursing Facility Services and Place of Service Codes) for location definitions and place of service codes for various settings where Nursing Facility E/M procedure codes may be reported.

DEFINITIONS:

Initial Comprehensive Visit – the initial visit in a Skilled Nursing Facility ("SNF") during which the **physician** completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident. Also, the initial visit in a Nursing Facility ("NF") during which the **physician or the APP** completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident.

Federally Mandated Visits – the required monthly visits that may be alternated between the physician and APP after the initial comprehensive visit is completed. 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.

Medically Necessary Visits – those visits necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

PROCEDURE:

I. Initial Nursing Facility Care and Readmissions – CPT codes 99304-99306

a. Only physicians may bill the initial nursing facility care service codes in a SNF setting (POS 31) for the initial admission or readmissions, regardless of whether the patient is new or established. The physician shall complete a thorough patient assessment, develop a plan of care, and write or verify admitting orders for the patient. The initial comprehensive visit must occur no later than 30 days after admission. This visit would be submitted using the "-AI" modifier. The "-AI" modifier indicates the billing physician is the principal physician of record.

b. Both physicians and APPs may perform and bill the initial comprehensive visit and bill the initial nursing facility care codes in a Nursing Facility ("NF") setting (POS 32) for the initial admission or readmissions, regardless of whether the patient is new or established. The physician or APP shall complete a thorough patient assessment, develop a plan of care, and write or verify admitting orders for the patient. The initial comprehensive visit must occur no later than 30 days after admission. This visit would be submitted using the "-AI" modifier. In a NF setting, the "-AI" modifier indicates the billing physician or billing APP is the principal physician of record.

II. Subsequent Nursing Facility Care – CPT Codes 99307-99310

a. After the initial comprehensive visit by the physician in the SNF setting, the physician may delegate alternate federally mandated visits to the APP. These visits would be reported with subsequent nursing facility codes with POS 31 for SNF setting.

b. After the initial comprehensive visit in the NF setting, a physician or APP may perform and report federally mandated visits. It is not necessary for the physician and APP to alternate visits. These visits would be reported as subsequent nursing facility codes with POS 32 for NF setting.

c. If an APP provides a medically necessary visit prior to the physician's performance of the initial comprehensive visit, a subsequent nursing facility code would be reported in either a SNF or NF setting.

III. Shared/Split Billing

Nursing Facility services cannot be shared/split between a physician and an APP. The billing provider must provide documentation that is sufficient to support the level of service billed.

IV. Incident-to Billing

a. Nursing Facility services (E/M codes or other services) shall not be billed in accordance with Medicare's incident-to provision.

b. Services performed by APPs in these settings must be billed under the APP's provider number and shall not be billed under the physician's provider number.

V. Discharge Services – CPT codes 99315 and 99316

a. Physicians and APPs may report a nursing facility discharge service code. The E/M visit must be a face-to-face encounter in order to bill for the discharge service.

b. The nursing facility discharge code 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.

c. Physicians and APPs may report a nursing facility discharge service code to report a death pronouncement if the physician or APP performed the pronouncement.

d. Nursing facility discharge day management codes are time-based codes. The documentation must include the time spent if greater than 30 minutes.

VI. Annual Nursing Facility Service – CPT Code 99318

a. CPT code 99318 may be used to report an annual nursing facility assessment (E/M visit) on an annual basis and may be reported by a physician or APP.

b. CPT code 99318 may be reported in lieu of a Subsequent Nursing Facility Care code (99307-99310) when the code requirements for 99318 are met.

c. The service represented by CPT code 99318 shall not be performed in addition to the required number of federally mandated E/M visits.

REFERENCES:

CMS. Medicare Claims Processing Manual Pub. # 100-04, Ch. 12, §30.6.13.
CMS. Center for Clinical Standards and Quality/Survey & Certification Group. S&C: 13-15-NH. March 8, 2013.
AMA. CPT 2020 Professional Edition. pp. 25-28.

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