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Wisconsin Physicians Service (WPS)

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Carrier

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LCD Title
Home and Domiciliary Services

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CMS National Coverage Policy
Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.
CMS Transmittal 775, Change Request 4212
Medicare Claims Processing Manual, Pub 100-4, Chapter 12, Section 30.6.14 –30.6.141
Medicare Program Integrity Manual, Pub 100-8, Chapter 13, Section 5.1
Medicare Benefit Policy Manual CMS Pub 100-2, 15, §50.3, §60.1, §60.2, §60.2, §60.3, and §60.4

Primary Geographic Jurisdiction
Wisconsin, Illinois, Michigan, Minnesota

Oversight Region
Region V

Original Determination Effective Date
04/16/2008

Original Determination Ending Date

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity
A home or domiciliary visit includes a beneficiary history, examination, problem solving and decision making in various levels depending upon a beneficiary's need and diagnosis.

The beneficiaries seen may have chronic conditions, may be disabled either physically or mentally making access to a traditional office visit very difficult, or may have limited support systems. The home or domiciliary visit in turn should lead to improved medical care by identification of unmet needs, coordination of treatment with appropriate referrals and potential reduction of acute exacerbations of medical conditions, resulting in less frequent trips to the hospital or emergency rooms.

Home-based health care and domiciliary health care services are rapidly expanding. Growth in hospital-based house call programs, early hospital discharge programs, and an increased effort to expand the role of house calls in medical education have contributed to this expansion. Physicians and non-physician providers (NPP) are required to oversee or directly provide progressively more sophisticated home visits. Beneficiaries must understand the nature of a pre-arranged visit and consent to treatment in the home or domiciliary care facility. Coverage for this type of service is based on face-to-face time only with the beneficiary alone or with the beneficiary and family or caregiver and the work performed during that time is documented in the chart, such as direct beneficiary assessment, care coordination etc. Travel time and related expenses are not separately billable services and as such should not be included when determining the CPT code that best defines the service rendered.

It is important to note that services performed to a beneficiary in a Residential Care Facilities/Rest Homes/Assisted Living Facilities is expected to occur in the beneficiary's own personal living space or a room set aside for such visits. In the event of the latter occurrence, such rooms are not considered a doctors office, and shall not be used for the routine performance of rounds on beneficiaries.

Medically necessary provider visits are payable under the physician fee schedule in Medicare Part B when provided to the beneficiary in his/her private residence. There is no requirement that the beneficiary must be homebound. To be reimbursable by Medicare, a home or domiciliary care visit that is in lieu of an office visit, ER visit or hospital visit, must meet all of the following criteria:

1. The service/visit must be medically reasonable and necessary and not for the convenience of the Medicare Part B provider or beneficiary.

2. The service must be of equal quality, as if it were performed in the office, including frequency of visits, which should be consistent with the frequency at any other site of service for that particular code and beneficiary condition. It is expected that the frequency of the visits for any given medical problem addressed in the home setting will not exceed that of an office setting.

   Services provided in the home or domiciliary setting must not unnecessarily duplicate services provided to the beneficiary by other practitioners, regardless of whether those practitioners provide the service in the office, facility or home/domiciliary setting. Home/domiciliary services provided for the same diagnosis, same condition or same episode of care as services provided by other practitioners, regardless of the site of service, may constitute concurrent or duplicative care.

   When such services are provided, the record must clearly document the medical necessity of such services. When documentation is lacking, the service may be considered not medically necessary.

The E/M service will not be considered medically necessary when it is performed only to provide supervision for a visiting nurse/home health agency visit(s).

3. The physician/qualified non-physician practitioner must be the provider of record and be responsible for managing the entire disease process addressed in the visit. All medical services provided to the beneficiary must be either ordered or personally performed by the provider.

4. Services provided to a beneficiary for the first time must be either requested by the beneficiary, his/her delegate, or another Medicare provider managing the beneficiary's care. The Medicare Part B provider cannot solicit the visit. Examples of visit solicitation include a provider arriving without an appointment to see a beneficiary or seeing a beneficiary for a scheduled, requested visit and then providing additional visits in a Residential Care Facility to other individuals in the facility without appropriate advance requests.

   The Medicare Part B provider or that provider's medical group practice who have an ongoing beneficiary-physician relationship with the beneficiary must provide follow-up visits. Exceptions include beneficiaries who are traveling through an area and are not residents in the location where they are being seen and beneficiaries who are being seen in their homes or domiciles for urgent or episodic illness.

5. Services provided to a beneficiary by a Medicare Part B **provider on the same day as** an employee of a home health agency cannot be duplicative or overlapping. Medicare Part B does not cover supervision for a visiting nurse/home health agency visit(s)**.**

   Beneficiaries receiving care under the home health benefit have a primary treating Medicare Part B provider working in concert with the home health agency and that service is billed using the care plan oversight service CPT codes. It is highly unlikely that additional Medicare Part B providers would be seeing/performing services for the beneficiary.

6. There is no "incident to" a physician's service in place of service home or domiciliary setting; therefore all drugs or services must be personally administered by the Medicare Part B provider. Medical necessity is not supported when the administration of the drug or biological is the sole reason for the visit.

7. Active wound care is not covered for beneficiaries who are also seen by home health agencies (HHA) because is included in the payment to the HHA. Medicare Part B providers who see beneficiaries for the evaluation of a wound must bill the appropriate evaluation and management (E&M) service.

8. Debridement of wounds must be billed with the appropriate CPT code and follow the guideline of LCD GSURG-037 and/or any other appropriate national or local coverage determination.

9. Services performed to beneficiaries who are also seeing other Medicare Part B providers in their offices for the same diagnosis will be assumed not medically necessary.

10. Visits to multiple beneficiaries by the same Medicare Part B provider or the same group may occur on the same date of service, but each service must meet the medical needs of the individual beneficiary. Each visit must stand on its own and the medical necessity of the visit must be supported in documentation. Each visit, which is part of an episode of care, must not exceed the

frequency of service that would be expected by the acceptable standards of medical practice for any other site of service.

This policy is subordinate to all National Coverage Determinations (NCDs), Medicare rules and regulations, and Local Coverage Determinations (LCDs) of this contractor for the specific test/procedure/service performed.

A. Requirement for Physician Presence

Home services codes 99341 – 99350 are paid when they are billed to report evaluation and management services provided to a beneficiary in their private residence. A home visit cannot be billed by a Medicare Part B provider unless the provider is actually present in the beneficiary's home and he/she personally performs the service.

B. Homebound Status

Under the home health benefit (Medicare Part A) the beneficiary must be confined to the home for services to be covered. For home services provided by a Medicare Part B provider using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

C. Diagnostic Tests

Code of Federal Regulations (CFR), Title 42, part 410.32, specifies that all diagnostic tests must be ordered by the provider who is the treating provider for the beneficiary and who will use the test results in the beneficiary's care. Tests not ordered by the physician who is treating the beneficiary and tests, which are not used in the management of the beneficiary's condition, are not reasonable and necessary. As with any service reimbursed by Medicare, to support medical necessity, there must be documentation in the medical record as to why a certain modality was chosen/performed.

Depending on a beneficiary's condition and in situations when life threatening and other severe adverse reactions could be expected as a result of the administration of certain drugs or the performance of other services, the administration/performance of these services must take place in a facility equipped and staffed for cardiopulmonary resuscitation and where the beneficiary can be closely monitored by qualified personnel for an appropriate period of time based on his or her health status. Such services performed in the home or domiciliary environment without appropriate oversight, qualified staff and equipment for reasonably foreseeable complications will not be considered medically necessary.

The primary treating physician must either personally perform the diagnostic test(s) or order the tests performed by mobile diagnostic testing facilities following LCD PHYS-078 Independent Diagnostic Testing Facilities (IDTFs).

Any specialized or invasive services, such as surgical procedures, physiologic monitoring, or advanced imaging performed during the course of home or domiciliary care visits must meet Medicare's reasonable and necessary criteria and must comply with all applicable safety rules and quality standards. If the results of the testing will not change the medical management or result in surgery, there is no medical necessity for the procedures. In these cases, the testing/service will not be medically necessary.

Laboratory and diagnostic tests performed during the course of home or domiciliary care visits must meet Medicare's reasonable and necessary criteria and be ordered by the primary care. A valid referring NPI number from a Medicare Part B provider who has previously seen the beneficiary must be on the claim. Medical reasons for repeat testing must be clearly documented. Performance of multiple or common tests without clear evidence of medical need of the beneficiary or changes in the treatment regimen based on the lab tests would not be considered reasonable and necessary as mandated by 42CFR410.32.

Coverage Topic
Home Health Care

Bill Type Codes:

999x Not Applicable

Revenue Codes:
99999 Not Applicable

CPT/HCPCS Codes

99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making
99325	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity
99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity
99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity
99341	Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making
99342	Home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity
99343	Home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity
99344	Home visit for the evaluation and management of a new patient, which requires these three

	components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity
99345	Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.
99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making.
99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity
99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity
99350	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity

Does the CPT 30% Rule Apply
No

ICD-9 Codes that Support Medical Necessity
Note: ICD-9 codes must be coded to the highest level of specificity.

XX000	Not Applicable

Diagnoses that Support Medical Necessity

XX000	Not Applicable

ICD-9 Codes that DO NOT Support Medical Necessity

XX000	Not Applicable

Diagnoses that DO NOT Support Medical Necessity

XX000	Not Applicable

Documentation Requirements
The medical record must document the medical necessity of all services performed during a home or domiciliary visit.

Documentation for billed visits must meet the required components of the E&M CPT code. The medical record must clearly support all the criteria and provisions contained in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy. Providers may also show need to assess a home situation, including involvement of caregivers. Clear documentation supporting the medical necessity of the home visit or domiciliary visit must be maintained in the beneficiary's record.

In support of this, the documentation of each beneficiary encounter must include at a minimum:
1. Reason for the encounter and relevant history
2. Physical examination findings, and prior diagnostic test results, if applicable
3. Assessment, clinical impression, or diagnosis

4. Medical plan of care

Thus, a payable diagnosis alone does not support medical necessity of ANY service. All documentation must be available to Medicare upon request.

Utilization Guidelines
It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. Frequency of visits should be consistent with the frequency at any other site of service for that code.

Sources of Information and Basis for Decision
American Academy of Home Care Physicians [online] at http://www.aahcp.org/index.shtml.
Landers, S.H. et al, Trends in House Calls to Medicare Beneficiaries. JAMA, 2005; 294: 2435-2436.
Levine, S.A., Boal, J, Boling, P.A., Home Care. JAMA. 2003; 290:1203-1206.
Oldenquist, GW, Scott, L, Finucane, TE, Home care: What a physician needs to know. Cleveland Clinic Journal of Medicine. 2001.68(5):433-440.
Stuck, AE et al., Home Visits to Prevent Nursing Home Admission and Functional Decline in Elderly People. JAMA. 2002; 287: 1022-1028.

Advisory Committee Meeting Notes
Meeting Date:

Wisconsin:	09/28/2007
Illinois:	09/26/2007
Michigan:	09/05/2007
Minnesota:	09/20/2007

Start Date of Comment Period
10/01/2007

End Date of Comment Period
11/16/2007

Start Date of Notice Period
(publication)
03/01/2008;

Revision History Number/Explanation

Reason for Change

Last Reviewed On

Notes
* - An asterisk indicates a revision to that section of the policy.

See companion document titled
Coding and Billing Guidelines for Home and Domiciliary Services (PHYS-081).

Does this LCD contain a "Least Costly Alternative" Provision?
No