

Contractor Name

Wisconsin Physicians Service (WPS)

Contractor Number

00951, 00952, 00953, 00954

Contractor Type

Carrier

LCD Database ID Number

Wisconsin

Illinois

Michigan

Minnesota

LCD Version Number

LCD Title

Home and Domiciliary Services

Contractor's Determination Number

PHYS-081

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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

CMS Consortium

Midwest

Original Determination Effective Date

Revision Effective 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.

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. The reason for a visit to the home rather than the office must be documented, as the visit is not payable or considered medically necessary if performed for the convenience of the Medicare Part B provider or beneficiary. Medical record documentation must support a medically necessary visit and made available to Medicare upon request.

It is important to note that services performed to beneficiaries in a Residential Care Facilities/Rest Homes/Assisted Living Facilities are 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.

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.

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.

3. The Medicare Part B provider must be the provider of record and be responsible for managing the entire disease process addressed in the visit. All services must either be 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. 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. Total billing time for the sum of all the day's domiciliary beneficiary visits at one site shall not exceed the provider's time at that site. 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

Note:

The Companion Billing and Coding Article lists services that are not normally performed for a beneficiary as part of Home and/or Domiciliary visits.

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 provider. 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.

Beneficiaries who need home health services seldom have a medical necessity for nerve conduction testing. Nerve conduction studies must follow LCD NEURO-005 Nerve Conduction Studies and Electromyography. In addition, the use of a simple hand-held or other Doppler device is not covered (See LCD CV 033 Non-Invasive Vascular Testing) and is considered merely an extension of the physical examination. If nerve conduction testing is performed in a place of service home or domiciliary facility, the beneficiary's plan of care must clearly document the purpose for the test. In addition, documentation must show how the results of the test will change the beneficiary's plan on care.

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

- 99337 detailed examination; medical decision making of moderate complexity
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
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Diagnoses that Support Medical Necessity

XX000	Not Applicable
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ICD-9 Codes that DO NOT Support Medical Necessity

XX000	Not Applicable
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Diagnoses that DO NOT Support Medical Necessity

XX000	Not Applicable
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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

Start Date of Notice Period

(Published)

Revision History Number/Explanation

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

Companion Billing and Coding Article
PHYS-081 - Home and Domiciliary Visits

Effective Date

Home and Domiciliary Visits

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. These visits are an extension of normal care. 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 can 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.

CMS National Coverage Policy:

Title XVIII of the Social Security Act section 1862 (a)(1)(A)

Title XVIII of the Social Security Act section 1862 (a)(7)

Title XVIII of the Social Security Act section 1833 (e)

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.

CMS Online Manual System, Pub.100-8, Program Integrity Manual, Chapter 13, Section 5.1

CPT Codes

1. Domiciliary, Rest Home, Assisted Living and/or Nursing Facility Codes

CPT code 99324 - 99337

Residential Care Facilities/Rest Homes/Assisted Living Facilities visits occur in the beneficiary's own personal living space or a room set aside for such visits. If the service is provided to a beneficiary for the first time, the beneficiary, his/her delegate, or another medical provider managing the beneficiary's care, must request the service. The visiting provider may not directly solicit referrals. An example of inappropriate solicitation is knocking on residents' doors or placing calls to residents on the telephone to offer mobile medical care services when there has been no referral from another professional that is already involved in the case.

2. Home Visit Codes

CPT code 99341 - 99350

Home visits services are provided in the beneficiaries private residence. The service must be of such nature that it could not be provided by a Visiting Nurse/Home Health Services Agency under the Home Health Benefit. There may be circumstances where home health services and the services of physician/qualified non-physician practitioners (NPPs) are performed on the same day. These services cannot be duplicative or overlapping. The service will not be considered medically necessary when it is performed only to provide supervision for a visiting nurse/home health agency visit(s).

If a beneficiary is receiving care under the home health benefit, the primary treating physician would be working in concert with the home health agency. It is highly unlikely that additional Medicare Part B providers would be seeing/performing services for beneficiaries receiving services under the home health benefit.

Coding Guidelines

1. If the provider is only rendering care for a limited condition, the service will be presumed not medically necessary, unless the provider of record requests a consultation and the care is medically necessary and clearly documented in the medical record.
2. 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.
3. 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 visits 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.
3. If laboratory and diagnostic tests are performed during the course of home or domiciliary care visits, they must meet Medicare’s reasonable and necessary criteria. 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.
4. 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 would not be medically necessary.

Diagnostic tests

Diagnostic tests performed during a home or domiciliary visit must be ordered or personally performed by the the physician/qualified NPP who is the provider of record and be responsible for managing the entire disease process addressed in the visit.

Note:

Data reviews show that the following services are billed typically inappropriately in place of service (POS) home. Since these services are not normally performed in POS Home (12), Assisted Living Facility (13) or Group Home (14) the claims will be subjected to the following coding guidelines or will be denied. If the service is submitted for review, the plan of care that shows the reason the service is being performed, a copy of the results of the tests and information explaining how the beneficiaries care is/was changed by the testing.

1. Cardiography

CPT codes 93000 - 93272

These services must be either personally performed by the Medicare Part B provider or a mobile IDTF following the CMS guidelines

2. Echocardiography

CPT codes 93303 - 93350

Report of an echocardiographic study, whether complete or limited, includes an interpretation of all obtained information, documentation of all clinically relevant finding including quantitative measurements obtained, plus a description of any recognized abnormalities. Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation and final,

written report, is not separately reportable. Therefore the following codes do not meet the description of a home or domiciliary services and will be denied when billed in POS 12, 13, or 14.

93307	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording,; complete
93308	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording,; follow-up or limited study
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study.
93325	Doppler color flow add-on
93350	Echo, transthoracic, real-time with image documentation (2D0, with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress

4 Noninvasive Vascular Diagnostic Studies

Vascular studies include beneficiary care required to perform the studies, supervision of the studies and interpretation of study results with copies for beneficiary records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided.

a. Cerebrovascular Arterial Studies

CPT codes 93875 - 93893

The use of a simple hand-held or other Doppler device is not covered and is considered merely an extension of the physical examination (See LCD CV 033 Non- Invasive Vascular Testing). The following codes do not meet the description of a home or domiciliary services and will be denied when billed in POS 12, 13, or 14.

93875	Noninvasive physiologic studies of extracranial arteries, complete bilateral study (eg, periobital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	Duplex scan of extracranial arteries, unilateral or limited study
93886	Transcranial Doppler Study of the intracranial arteries, complete study

b. Extremity Arterial Studies

CPT codes 93922 - 93931

The use of a simple hand-held or other Doppler device is not covered (See LCD NEURO-005). The following codes do not meet the description of a home or domiciliary services and will be denied when billed in POS 12, 13, or 14.

c. Extremity Venous Studies (Including Digits)

CPT codes 93965, 93970 and 93971

The above three services may be billed in place of service 12, 13 or 14, when medically necessary, ordered by the beneficiaries primary provider, and rendered by mobile diagnostic testing facilities. See LCD PHYS-078

d. Visceral and Penile Vascular Studies

CPT codes 93975 - 93978

Visceral and Penile Vascular studies do not meet the description of a home or domiciliary services and will be denied when billed in POS 12, 13, or 14.

**5. Routine Electroencephalography
CPT codes 95812 - 95830**

The use of a portable, hand-held, noninvasive, automated nerve conduction testing device is not covered (See LCD NEURO-005). All nerve conduction studies must follow the guidelines in LCD NEURO-005 Nerve Conduction Studies and Electromyography and any other appropriate LCD, NCD or Medicare regulation.

Beneficiaries who need home health services seldom have a medical necessity for nerve conduction testing. Nerve conduction studies must follow LCD NEURO-005 Nerve Conduction Studies and Electromyography. In addition, the use of a simple hand-held or other Doppler device is not covered (See LCD CV 033 Non- Invasive Vascular Testing) and is considered merely an extension of the physical examination. If nerve conduction testing is performed in a place of service home or domiciliary facility, the beneficiaries plan of care must clearly document the purpose for the test. In addition, documentation must show how the results of the test will change the beneficiaries plan on care.

Initial claims billed in POS 12, 13, or 14 will be denied, claims submitted for a reconsideration must include a copy of the test result and the beneficiaries plan of care.

Diagnoses that Support Medical Necessity

The mere presence of inactive or chronic conditions does not constitute medical necessity for any setting (home, rest home, office etc). There must be a chief complaint or a specific reasonable and medically necessary need for each visit. In support of this, the documentation of each beneficiary encounter must include:

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 including how positive results will change the care of the beneficiary.

Thus, a payable diagnosis alone does not support medical necessity of ANY service. Medical necessity must exist for each individual visit. The visit will be regarded as a visit of convenience, unless the medical record clearly documents the necessity for each visit.

Reasons for Denial

1. The record does not clearly demonstrate that the beneficiary, his/her delegate or another clinician involved in the case sought the initial service.
2. The service is provided at a frequency that exceeds that which is typically provided in the office and acceptable standards of medical practice.
3. The service is solicited.
4. The beneficiary is treated by other providers in their offices for the same diagnosis
5. The initial visit and the majority of subsequent visits are scheduled to coincide with multiple other visits by the provider in the same facility.
6. The record does not clearly demonstrate that the beneficiary, his/her delegate or the primary physician/provider sought the initial service.
7. The same service is being provided simultaneous to a large number of beneficiaries in the same facility.
8. The service is provided at a frequency that exceeds that which is typically provided in the office.
9. The service is not personally performed or ordered by the rendering/billing provider.
10. The service is not medically necessary and/or abnormal results will not change the beneficiaries plan of care.

Physician services performed under the 'incident to guidelines' (LCD PHYS-004) are not covered in place of service Home, Domiciliary, Rest Home, Assisted Living and/or Nursing Facility.

Original Effective Date

Revision History Number/Explanation

Publication Date

Notes

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