

Billing and Coding Guidelines

L31613 PHYS-081 - Home and Domiciliary Visits

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Contractor Number

00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302,
05402, 52280

Contractor Type

Carrier
Fiscal Intermediary A
MAC A
MAC B

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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

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.

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. Based on the Consolidative Billing Regulations, no service will be covered under Medicare Part B when 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. 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.
2. 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 repeated 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.
3. 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.
4. 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.

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 the visit will change/changed the care of the beneficiary.

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 social visit unless the medical record clearly documents medical necessity for every 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 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 without documentation of medical necessity.
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 beneficiary's 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

06/15/2011

Revision History Number/Explanation

Publication Date

05/01/2011

Notes

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