Summary of Comments PHYS-081 Home and Domiciliary Services

WPS thanks all providers for their comments. Many changes/updates were made to LCD L31613 derived from this process.

Comment:
The word "convenience" below should be clarified.

> **Diagnoses that Support Medical Necessity**
> 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.

Response:
The LCD now reads:

> 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 social visit unless the medical record clearly documents medical necessity of every visit.

National Medicare regulations require a reason for a home visit. It cannot be merely for beneficiary convenience. MCPM, Pub 100-4, Chapter 12, Section 30.6.14 –30.6.141

Comment:
The LCD says:

> "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. "

We question the draft LCD's apparent unequivocal equation of home visits and office visits. Home visits and office visits have historically been valued differently in the Medicare physician fee schedule, reflecting, among other things, the different patient mixes involved. Also, we are concerned with reference to an undefined frequency limitation for home visits based on an equally undefined frequency of visits for office visits. Medical necessity, which is the first coverage criterion in the draft LCD, is sufficient to address the concerns at which the second criterion, above, seems aimed.

Response:
This statement was placed in the LCD because a post payment review of medical records did not show documentation that was of a greater complexity than the office visit but in fact showed documentation that was much less than what one would expect to see for an office visit. In addition, the numbers of visits billed in POS home were more frequent with no documentation to support the medical necessity of the services. Medical necessity is paramount for any service, regardless of place of service.

The LCD now reads:
"The minimum level of documentation of a home visit should be that which is rendered in the office with, given the fact that home visits historically have had a higher level of reimbursement, the expectation that the level of documentation would be more complex."

Comment:

Based on the information below, if a Family Practice physician sees a patient with congestive heart failure, would he get denied payment because the Cardiologist only sees the patient infrequently?

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.

Response:
As the LCD states in the beginning of the policy, a payable diagnosis alone does not support medical necessity of ANY service. Medical necessity must exist for each individual visit. If one's documentation supports the necessity for the service it would be considered for coverage. However concurrent care is always a potential issue for all services billed to Medicare.

Comment:
I am a family physician who performs visits to selected beneficiary's home and domiciliary (CBRF). I am pleased to see the elimination of the requirement for home bound status. Much can be learned in seeing the patient in their home. I doubt we will see a dramatic resurgence in the concept of the "house call". Increasing the RVU associated with this time-consuming service is the next step.

Response:
Thank you for your comment. WPS already has seen an increase in the billing of house calls and will, as will other agencies, be performing reviews of these services. WPS does not have any input in the calculation of RVU's.

Comment:
We have a concern relating to the fifth coverage criterion, which states in part:

> "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**)."**

The desire to avoid duplicative services makes sense to us. However, Medicare should not automatically deny coverage of a physician's home visit in a situation where a visiting nurse or home health agency provided service on the same date. As noted below, there are situations (e.g., wound care) in which it is medically necessary and appropriate for a physician and home health agency personnel to provide services to the same patient on the same date.
We believe the restrictive nature of the language in this section needs to be changed to allow for physician and home health agency (HHA) nurse interaction at the bedside, in the home of patients needing services partially provided by the physician and partially provided by the HHA. An example is wound care in which the HHA nurse may request physician assistance in assessing and changing the plan of care. At a time when family physicians are being encouraged to engage in team based care, rules such as this make it even more difficult to do so.
Accordingly, we would encourage you to revise the section in question to read as follows:

> In general, it is expected that services will not be duplicative or overlapping, or that the physician is providing supervision only. However, there may be situations in which developing or changing a plan of care for conditions that both the physician and HHA are managing (e.g., wound care, etc.) may require in home, on site consultation by both parties that is overlapping. In these cases, the physician's chart should document the need for this collaborative visit.

Response:
LCD now reads:
"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)."

Based on the Consolidative Billing Regulations, Medicare Part B does not cover supervision of a Home Health Agency (HHA) Nurse or their personal. If this service is necessary, the physician should discuss reimbursement with the HHA. If a service is denied by Medicare Part B and a provider feels that it should be covered there should be a request for a reconsideration of the service.

Comment:
There is a concern regarding criterion which states, in part:

> "Medical necessity is not supported when the administration of the drug or biological is the sole reason for the visit."

We understand the intent of this statement to be "Medical necessity of the home or domiciliary care visit is not supported when the administration of the drug or biological is the sole reason for the visit." That would be a true statement, since administration of a drug or biological by itself does not justify the reporting of an evaluation and management service. However, as the statement currently reads in context, it implies that administration of a drug or biological in the home or domiciliary care setting would not be covered if that was the sole service provided. As noted, we don't believe that is the intent of the statement, and addition of the phrase "of the home or domiciliary care visit" would clarify the true intent, from our perspective.

Response:
Criterion states, "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."

WPS agrees and has added the words "of the E & M service". It now reads:
"Medical necessity of the home or domiciliary care visit is not supported when the administration of the drug or biological is the sole reason for the visit." Thank you

Comment:
We have the criterion which states:

> "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."

We believe it is completely unfair to penalize physicians who do provide home visits because other physicians, typically subspecialists, will not. We believe that this criterion should be revised to read, "Services performed to beneficiaries who are also seeing other Medicare Part B primary care providers in their offices for the same diagnosis will be assumed not medically necessary." (Emphasis added)

Response:
The issue here is two providers seeing the same beneficiary/same service/same reason. There is no issue if the subspecialist is seeing the beneficiary for a reason different than the primary care provider and documentation supports this. If two providers are seeing the beneficiary for the same diagnosis, they need to discuss this and be aware that one of the visits may be denied for concurrent care. The general Medicare rule is, first claim in gets paid.

The LCD now reads:

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

Comment:

We would like to comment on the HCPCS codes in the 976xx series are not being billable when the beneficiary is being seen by a Home Health Agency (HHA).

Response:

While the CPT code 976xx series are not in this LCD, the Consolidated Billing Regulations is a national requirement binding on all Medicare contractors. All of the language regarding Home Health (HH) consolidated billing was also in the previous LCD PHYS-081 Home and Domiciliary Services L26230.

Under the HH Consolidated Billing Regulations, regardless who is performing the service, if a beneficiary is seen by a Home Health Agency, wound care is part of the Home Health benefit. If you object you should address this to the Center for Medicare and Medicare Systems (CMS).

Comment:

In the past there were separate codes for physicians and for physical therapists, the 976xx series being the therapist codes which were included in the Home Health payments.

Response:

Again, these codes are not in this LCD. The 2011 CPT Code book does not restrict the 97597-97606 to any provider specialty. In addition, there have long been the following instructions in the CPT Code book:

"It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified health care professional."