

# CPT CODE 99308

## SUBSEQUENT NURSING FACILITY CARE

# FACT SHEET

### Subsequent Nursing Facility Services

Components Required: 2 of 3	99307	99308	99309	99310
<b>History &amp; Exam</b>				
Problem Focused	●			
Expanded problem focused		●		
Detailed			●	
Comprehensive				●
<b>Medical Decision Making</b>				
Straightforward	●			
Low		●		
Moderate			●	
High				●
<b>Presenting Problem (Severity)</b>				
Stable/recovering/improving	●			
Responding inadequately to therapy/minor complication		●		
Significant complication/significant new problem			●	
Unstable/significant new problem requiring immediate physician attention				●
<b>Typical Time: Face-to-Face</b>	<b>10</b>	<b>15</b>	<b>25</b>	<b>35</b>

Medicare allows only the medically necessary portion of a **face-to-face** visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level/medical necessity of any service.

For billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013 physicians may use the 1997 documentation guidelines or an extended history of present illness.

### Problem Focused History

- Chief complaint/reason for visit
- Brief history of present illness
  - Brief should describe one to three elements of HPI
- Problem pertinent system review

### HPI – History of Present Illness

A chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. Descriptions of present illness may include:

**Documentation MUST establish medical necessity for visits occurring OUTSIDE federally regulated visits.**

Reporting Federally Mandated Visits (CPT Codes 99307-99310): <http://www.cgsmedicare.com/partb/pubs/news/2014/0114/cope24339.html>

This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services submitted to Medicare must meet Medical Necessity guidelines. The definition of "medically necessary" for Medicare purposes can be found in Section 1862(a)(1)(A) of the Social Security Act – Medical Necessity ([http://www.ssa.gov/OP\\_Home/ssact/title18/1862.htm](http://www.ssa.gov/OP_Home/ssact/title18/1862.htm)).

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- Location
- Quality
- Duration
- Severity
- Timing
- Context
- Modifying factors
- Associated signs/symptoms significantly related to the presenting problem(s)

## Chief Complaint

The Chief Complaint is a concise statement from the patient describing:

- The symptom
- Problem
- Condition
- Diagnosis
- Physician recommended return, or other factor that is reason for the encounter.

## Review of Systems

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purpose of Review of Systems the following systems are recognized:

- Constitutional (i.e., fever, weight loss)
- Cardiovascular
- Integumentary (skin and/or breast)
- Eyes
- Respiratory
- Psychiatric
- Ears, Nose, Mouth, Throat
- Gastrointestinal
- Endocrine
- Genitourinary
- Hematologic/Lymphatic
- Musculoskeletal
- Allergic/Immunologic

## Past, Family, And/or Social History (PFSH)

Consists of a review of the following:

- Past history (patient's past experiences with illnesses, operations, injuries, and treatments)
- Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
- Social history (an age appropriate review of past and current activities)

## Medical Decision making of LOW complexity

Documentaton must meet or exceed 2 of the following 3:

- Limited management options for diagnosis or treatment
- Limited amount of data to be reviewed consisting of the following:
  - Lab/Diagnostic/Imaging results
  - Charts/notes from other practitioner's (i.e. PT, OT, consultants)
  - Documentation of labs or diagnostics still needed
- Low risk of complications and/or morbidity or mortality
  - Comorbidities associated with the presenting problem
  - Risk(s) of diagnostic procedures(s) performed
  - Risk(s) associated with possible management options

### Expanded Problem Focused Exam:

- A limited exam of the affected body are or organ system
- Other symptomatic or related organ system(s)
- Body areas recognized:
  - Head/including face
  - Neck
  - Chest/including breasts and axilla
  - Abdomen
  - Genitalia/groin and buttocks
  - Back
  - Each extremity
- Organ systems recognized
  - Eyes, ears, nose, mouth, throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hematologic/Lymphatic/Immunologic

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## Additional Information

- Consultation codes may not be submitted on Medicare claims for visits in SNFs and NFs.
- In all cases, documentation in the patient's medical record must support the medical necessity for services submitted (including the level of E/M service).
- Submit claims for the first E/M service for a Medicare beneficiary in a SNF or NF during the patient's facility stay, even if that service is provided prior to the federally mandated visit, with the most appropriate E/M code that reflects the services the practitioner furnished.
- Practitioner's choosing to use time as the determining factor:
  - MUST document time in the patient's medical record
  - Documentation MUST support in sufficient detail the nature of the counseling
  - Code selection based on total time of the face-to-face encounter (floor time), the medical record MUST be documented in sufficient detail to justify the code selection
- Face-to-face time refers to the time with the physician ONLY. The time spent by other staff is NOT considered in selecting the appropriate level of service

Medicare will pay 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. Submit CPT codes 99307-99310 (Subsequent Nursing Facility Care, per day) in the following circumstances:

- Federally mandated physician visits and other medically necessary visits
- Medically necessary Evaluation & Management (E/M) services, even if they are provided prior to the initial visit by the physician
- Medically complex care in a Skilled Nursing Facility (SNF) upon discharge from an acute care visit, even if the visits are provided prior to the physician's initial visit

**Ohio Regulations regarding medical supervision:**

- Each resident of a nursing home shall be under the supervision of a physician.
- Each resident of a nursing home shall be evaluated by a physician or other licensed health professional acting within the applicable scope of practice, at least once every thirty days for the first ninety days after admission or three evaluations.
- After this period, each resident of a nursing home shall be evaluated by a physician or other licensed health professional acting within the applicable scope of practice at least every sixty days, except if the attending physician documents in the medical record why it is appropriate.
- The resident may be evaluated no less than once every 120 days.
- The evaluations required by this rule shall be made in person. In conducting the evaluation, the physician or licensed health professional shall solicit resident input to the extent of the resident's capabilities.

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- The physician or licensed health professional shall write a progress note after each evaluation depicting the current condition of the resident based upon consideration of the physical, mental and emotional status of the resident.
- A physician or licensed health professional visit is considered timely if it occurs no later than 10 calendar days after the date the visit was required.

**Kentucky Regulations regarding medical supervision:**

- The health care of each patient shall be under supervision of a physician who, based on an evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of medical care which covers indicated medications, treatments, rehabilitative services, diet, special procedures recommended for the health and safety of the patient, activities, plans for continuing care and discharge.
- Patients shall be evaluated by a physician at least once every 30 days for the first 90 days following admission. Subsequent to the 90th day following admission, the patient shall be evaluated by a physician every 60 days. There shall be evidence in the patient's medical record of the physician's visits to the patient at appropriate intervals.
- There shall be evidence in the patient's medical record that the patient's attending physician has made arrangement for the medical care of the patient in the physician's absence.
- The facility shall have arrangements with one (1) or more physicians who will be available to furnish necessary medical care in case of an emergency if the physician responsible for the care of the patient is not immediately available.

**References**

- CMS Publication 100-04, Chapter 12, sec 30.6; Evaluation and Management Service Codes <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>
- Medicare Learning Network; Documentation Guidelines for Evaluation and Management (E/M) Services <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>
- Subsequent Nursing Facility Care (CPT Codes 99307-99310): Claim Submission and Documentation <https://www.cgsmedicare.com/partb/pubs/news/2013/0313/cope21584.html>
- Reporting Federally Mandated Visits (CPT Codes 99307-99310) <http://www.cgsmedicare.com/partb/pubs/news/2014/0114/cope24339.html>
- American Medical Association CPT (current procedural terminology) Codebook

Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219. (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf>). You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters article MM6698. (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf>) A sample attestation statement is available on the CGS website ([http://www.cgsmedicare.com/partb/cert/attestation\\_form.pdf](http://www.cgsmedicare.com/partb/cert/attestation_form.pdf)). Guidelines regarding signature requirements are located in CMS Publication 100-08, Chapter 3, section 3.3.2.4 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>).