CPT CODE 99350

ESTABLISHED PATIENT, HOME VISIT

FACT SHEET

Home Services (Established Patients)

Components Required: 2 of 3	99347	99348	99349	99350
History & Exam				
Problem Focused	●			
Expanded problem focused		●		
Detailed			●	
Comprehensive				●
Medical Decision Making				
Straightforward	●			
Low		●		
Moderate			●	
High				●
Presenting Problem (Severity)				
Self-limited or minor	●			
Low to moderate		●		
Moderate to high			●	
Moderate to high/unstable/significant new problem				●
Typical Time: Face-to-Face	**15**	**25**	**40**	**60**

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.

Comprehensive History

- Chief complaint/reason being seen in the Home on this date of service (not just list of diagnoses)
- Extended history of present illness (HPI)
  - Extended includes four or more elements of HPI
  - Complete review of systems directly related to the problem(s) identified in the HPI
  - Include medically necessary review of at least 10 body systems
  - Review is the patient's response to any issues or symptoms with that system (a Positive or negative response is required).
- Medically necessary complete past, family , and social history

Four or more elements of the HPI or the status of at least three (3) chronic, acute, or inactive conditions, noting that medical necessity is ALWAYS the overarching criterion.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

FACT SHEET

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ESTABLISHED PATIENT, HOME VISIT

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:

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

Moderate Complexity Medical Decision Making

Documentation must meet or exceed 2 of the following 3:

Moderate Complexity:

- Multiple management option for diagnosis or treatment
- Moderate 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
- Moderate risk of complications and/or morbidity or mortality:
  - comorbidities associated with the presenting problem;
  - risk(s) of diagnostic procedure(s) performed;
  - risk(s) associated with possible management options

High Complexity Medical Decision Making

Documentation must meet or exceed 2 of the following 3:

- Extensive management options for diagnosis or treatment
- Extensive 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
- High risk of complications and/or morbidity or mortality: comorbidities associated with the presenting problem; risk(s) of diagnostic procedure(s) performed; risk(s) associated with possible management options.

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)
- Eyes
- Ears, Nose, Mouth Throat
- Cardiovascular
- Respiratory

Comprehensive physical exam:

- General, multisystem exam OR complete exam of a single organ system
- 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

- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Additional Information:

- Comorbidities and other underlying diseases in and of themselves are not considered when selecting the E/M codes UNLESS their presence significantly increases the complexity of the medical decision making.
- Practitioner's choosing to use time as the supporting factor:
  - Must document time spent in counseling not just a percentage of 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.

Signatures

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). 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).

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
- American Medical Association CPT (current procedural terminology) Codebook

Chief Complaint:

Chief Complaint is a concise statement from the patient describing: the reason for being seen on this date of service in the home, not just a list of the diagnoses or "reason for encounter in lieu of office visit":

- The symptom
- Problem
- Condition
- Diagnosis

Physician recommended return, or other factor that is reason for the encounter.

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)