## Coverage Summary

### Evaluation and Management Services

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<tr>
<th>Policy Number</th>
<th>Products</th>
<th>Original Approval Date</th>
<th>Approved by</th>
<th>Last Review Date</th>
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<tr>
<td>E-001</td>
<td>UnitedHealthcare Medicare Advantage Plans</td>
<td>02/18/2009</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>01/15/2019</td>
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### Related Medicare Advantage Policy Guidelines:

- **Consultation Services Rendered by a Podiatrist in a Skilled Nursing Facility (NCD 70.2)**
- **Consultations with a Beneficiary's Family and Associates (NCD 70.1)**
- **Physician's Office Within an Institution-Coverage of Services and Supplies Incident to a Physician's Services (NCD 70.3)**

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This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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### I. COVERAGE

**Coverage Statement:** Evaluation and management services are covered when Medicare coverage criteria are met.

**Guidelines/Notes:**

1. **Physician Office in a Facility**

   Physicians may have an office within a nursing home or other institution. Where a physician
establishes an office within a nursing home or other institution, coverage of services and supplies furnished in the office must be determined in accordance with the "incident to a physician's professional service" provision, as in any physician's office. A physician's office within an institution must be confined to a separately identified part of the facility which is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Thus, services performed outside the "office" area would be subject to the coverage rules applicable to services furnished outside the office setting.

For full description, see the NCD for Physician's Office Within an Institution -- Coverage of Services and Supplies Incident to Physician's Services (70.3). (Accessed December 14, 2018)

Incident to a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.

See the Medicare Benefit Policy Manual, Chapter 15, Section 60.1 - Incident To Physician’s Professional Services. (Accessed December 14, 2018)

2. Physician Consultation with a Patient’s Family and Associates
   a. In certain types of medical conditions, including when a patient is withdrawn and uncommunicative due to a mental disorder or comatose, the physician may contact relatives and close associates to secure background information to assist in diagnosis and treatment planning. When a physician contacts his patient's relatives or associates for this purpose, expenses of such interviews are properly chargeable as physician's services to the patient on whose behalf the information was secured. If the beneficiary is not an inpatient of a hospital, reimbursement for such an interview is subject to the special limitation on payments for physicians' services in connection with mental, psychoneurotic, and personality disorders.

   b. In some cases, the physician will provide counseling to members of the household. Family counseling services are covered only where the primary purpose of such counseling is the treatment of the patient's condition.

   For example, two situations where family counseling services would be appropriate are as follows: (1) where there is a need to observe the patient's interaction with family members; and/or (2) where there is a need to assess the capability of and assist the family members in aiding in the management of the patient.

   Counseling principally concerned with the effects of the patient's condition on the individual being interviewed would not be reimbursable as part of the physician's personal services to the patient. While to a limited degree, the counseling described in the second situation may be used to modify the behavior of the family members, such services nevertheless are covered because they relate primarily to the management of the patient's problems and not to the treatment of the family member's problems.

   See the NCD for Consultation Services with a Beneficiary's Family and Associates (70.1). (Accessed December 14, 2018)

3. Pronouncement of Death

   Physician services for the pronouncement of death are covered. See the NCD for Pronouncement of Death (70.4). (Accessed December 14, 2018)

4. Podiatrist Consultation in a Skilled Nursing Facility
Podiatrist consultant services are covered in a Skilled Nursing Facility if the signs and symptoms meet coverage criteria for foot care. See the *NCD for Consultation Services Rendered by a Podiatrist in a Skilled Nursing Facility (70.2)*. (Accessed December 14, 2018)

5. **Hospital and Skilled Nursing Facility Admission Diagnostic Procedures**

Hospital and skilled nursing facility (SNF) admission diagnostic procedures are covered when the diagnostic procedures are reasonable and necessary. The major factors which support a determination that a diagnostic procedure performed as part of the admitting procedure to a hospital or skilled nursing facility is reasonable and necessary are:

a. The test is specifically ordered by the admitting physician (or a hospital or skilled nursing facility staff physician having responsibility for the patient where there is no admitting physician): i.e., it is not furnished under the standing orders of a physician for his patients;

b. The test is medically necessary for the diagnosis or treatment of the individual patient's condition; and

c. The test does not unnecessarily duplicate the same test performed on an outpatient basis prior to admission or performed in connection with a recent hospital or skilled nursing facility admission.

*See the *NCD for Hospital and Skilled Nursing Facility Admission Diagnostic Procedures (70.5)*. (Accessed December 14, 2018)*

*Also see* Coverage Summary for Physician Services, Coverage Summary for Skilled Nursing Facility (SNF) Care and Exhaustion of SNF Benefits and Coverage Summary for Hospital Services (Inpatient and Outpatient).*

### II. DEFINITIONS

### III. REFERENCES

See above

### IV. REVISION HISTORY

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| 04/01/2019 | Updated policy introduction; added language to clarify:  
**  There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)  
**  In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*) |
| 01/15/2019 | Annual review; no updates. |
| 01/16/2018 | Annual review; no updates. |
| 01/17/2017 | Annual review; no updates. |
01/19/2016  Annual review; no updates.
01/20/2015  Annual review with the following update:
            Guideline 1 (Physician Office in Facility) - Added the definition of incident to a
            physician’s professional services
02/18/2014  Annual review; no updates.
02/19/2013  Annual review; no updates.
02/27/2012  Annual review; no updates.
02/21/2011  Annual review; no updates.
08/26/2010  Reference/link to LCDs for Evaluations and Management Visits and Coding deleted;
            LCDs no longer available.