**Coverage Summary**

**Physician Services**

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<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 02/19/2019</td>
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**Related Medicare Advantage Policy Guidelines:**

- Counseling to Prevent Tobacco Use (NCD 210.4.1)
- Telephone Transmission of EEGs (NCD 160.21)

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**Coverage Summary: Physician Services**

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 comply 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: Physician/practitioner services are covered when Medicare coverage criteria are met.

Guidelines/Notes:

1. Reasonable and necessary physician/practitioner services are covered. (See Definition Section for Medicare’s definition of physician/practitioner). Examples include, but are not limited to:
   a. Diagnosis, therapy, surgery, and consultation rendered by a licensed provider
   b. Elimination of the Use of Consultation Codes: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS will no longer recognize office/outpatient consultation CPT codes for payment of office/outpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all office/outpatient visits.
      For detailed coding information regarding this change, refer to the Medicare Claims Processing Manual, Chapter 12, §30.6.10 - Consultation Services. Also see §190.3 for telehealth services. (Accessed January 14, 2019)
   b. Patient-Initiated Second Opinions
      Consultation by a second physician at the request of the member and/or attending provider, which includes a written report of the history and physical of the member.
      Also see the Coverage Summary for Second and Third Opinions.
   c. Administration of injectable drugs and medications in the physician's office as routine part of the medical office visit
      See the Medicare Benefits Manual, Chapter 15, §50.3 - Incident To Requirements. (Accessed January 14, 2019)
   d. Preventive health examinations
      Also see the Coverage Summary for Preventive Health Services and Procedures.
   e. Concurrent Care
      Concurrent care exists where more than one physician renders services more extensive than
consultative services during a period of time. The reasonable and necessary services of each
given that each is required to play an active role in the patient’s treatment, for example, because of the existence of more than one
medical condition requiring diverse specialized medical services.


f. Care Plan Oversight Services
Care plan oversight is supervision of patients under care of home health agencies or
ehospices that require complex and multidisciplinary care modalities involving regular
physician development and/or revision of care plans, review of subsequent reports of patient
status, review of laboratory and other studies, communication with other health
professionals not employed in the same practice who are involved in the patient’s care,
integration of new information into the care plan, and/or adjustment of medical therapy.

Such services are covered for home health and hospice patients, but are not covered for
patients of skilled nursing facilities (SNFs), nursing home facilities, or hospitals.

*For specific coverage requirements, see the Medicare Benefits Manual, Chapter 15, §30.G - Care Plan Oversight Services.* (Accessed January 14, 2019)

g. Home Visits (House Calls)
**Requirement for Physician Presence:** Home services codes 99341-99350 are paid when
they are billed to report evaluation and management services provided in a private
residence. A home visit cannot be billed by a physician unless the physician was actually
present in the beneficiary’s home.

**Homebound Status:** Under the home health benefit the beneficiary must be confined to the
home for services to be covered. For home services provided by a physician using these
codes, the beneficiary does not need to be confined to the home. The medical record must
document the medical necessity of the home visit made in lieu of an office or outpatient
visit.

*See the Medicare Claims Processing Manual, Chapter 12, §30.6.14 - Home Care and

*Also see the Medicare Benefit Policy Manual, Chapter 7, §30.1 - Patient Confined to the
Home.* (Accessed January 14, 2019)

Local Coverage Determinations (LCDs) for E & M and Domiciliary Visits exist and
compliance with these policies is required where applicable. These LCDs are available at
(Accessed August 21, 2019)

h. Phone Consultations
Physician consultations by phone to a member or his/her family is an integral part of
physician pre or post work of physician services and should not be billed separately. (*Note:
This is not Telemedicine. For coverage guideline for telemedicine services, see the
Coverage Summary for Telemedicine/Telehealth Services.*


i. Critical Care Visits and Neonatal Intensive Care Visits
Physicians and non-physician practitioners (NPPs) may bill for critical care visits and
Neonatal Intensive Care visits that meet Medicare’s criteria and definition of Critical Care (see Definitions Section below).

See the Medlearn Matters # 5993 Critical Care Visits and Neonatal Intensive Care. (Accessed January 14, 2019)

Also see the Medicare Claims Processing Manual, Chapter 12, §30.6.12 - Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292). (Accessed January 14, 2019)

2. Examples of other covered physician/practitioner services that are also covered include, but are not limited to:

a. Physician services furnished in connection with dialysis sessions for outpatients who are on maintenance dialysis in an ESRD facility or at home; see the Medicare Benefit Manual Chapter 11, §40 – Other Services. (Accessed January 14, 2019)


Also see the Coverage Summary for Maternity and Newborn Care and Coverage Summary for Infertility Services.


Also see the Coverage Summary for Allergy Testing and Allergy Immunotherapy.

d. Podiatric and chiropractic physician services; see the Medicare Benefit Policy Manual, Chapter 15, §30.5 - Chiropractor’s Services. (Accessed January 14, 2019)

Also see the Coverage Summary for Chiropractic Services.

e. Tobacco cessation counseling, through the treating physician, when a member has a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or who is taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on FDA-approved information.

*Note: Inpatient hospital stays with the principal diagnosis of Tobacco Use Disorder, are not reasonable and necessary for the effective delivery of tobacco cessation counseling services. Therefore, we will not cover tobacco cessation services if tobacco cessation is the primary reason for the patient’s hospital stay.*

See the NCD for Smoking and Tobacco Use Cessation Counseling (210.4) and NCD for Counseling to Prevent Tobacco Use (210.4.1). (Accessed January 14, 2019)

Also see the Coverage Summary for Preventive Health Services and Procedures.

f. Coumadin (anti-coagulation) monitoring performed at a free-standing clinic or a clinic within a hospital or that is attached to a hospital

See the Medicare Benefit Policy Manual, Chapter 15, §60.3 - Incident To Physician’s Services in Clinic. (Accessed January 14, 2019)

g. Monitored Anesthesia Care (MAC)

Payment for Anesthesiology Services - Monitored Anesthesia Care (MAC).

MAC involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the
performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care.

The A/B MAC pays for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services.

**For additional information:**


Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the *LCD Availability Grid (Attachment A)*. (Accessed November 6, 2019)

h. Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia, and general anesthesia. Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation, or monitored anesthesia care.

In 2017, the CPT added new codes 99151-99153, 99155-99157 and G0500 for moderate or conscious sedation.

CPT codes 99151 to 99153 describe moderate sedation provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status. Appendix G [“Summary of CPT® Codes That Include Moderate (Conscious) Sedation”] has been removed from the CPT® 2017 code book. The value related to moderate sedation has been removed from the codes previously listed in Appendix G. CPT codes 99155 to 99157 describe moderate sedation provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports. G0500 describes moderate sedation by the same practitioner when that practitioner is performing an endoscopy service (the pertinent codes are 43200 through 45398, G0105 and G0121).

If the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, then the conscious sedation code should not be reported and no payment should be allowed by the carrier. There is no CPT code for the performance of local anesthesia and as payment for this service is considered in the payment for the underlying medical or surgical service.

**For additional information, see the Medicare Claims Processing Manual, Chapter 12, §50.J- Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services.** (Accessed January 14, 2019)

i. Telephone transmission of EEGs (as a physician's service or as incident to a physician's service) when reasonable and necessary for the individual patient, under appropriate circumstances.

**Note:** The service is safe, and may save time and cost in sending EEGs from remote areas without special competence in neurology, neurosurgery, and electroencephalography, by
avoiding the need to transport patients to large medical centers for standard EEG testing.

See the NCD for Telephone Transmission of Electroencephalograms (EEGs) (160.21).
(Accessed January 14, 2019)

3. **Examples of physician/practitioner services that are not covered include, but are not limited to:**
   a. Treatment for any illness or injury when not attended by a licensed physician, surgeon, or healthcare professional; see the Medicare Benefits Manual, Chapter 15, §30 - Physician Services. (Accessed January 14, 2019)
   b. Employer requests for clearance to work or documentation as a reason for missed work; see the Medicare Benefit Policy Manual, Chapter 16, §20 - Services Not Reasonable and Necessary. (Accessed January 14, 2019)
   c. Completion of forms, e.g., insurance, employment, school, sports, summer camp, Department of Motor Vehicle (DMV), etc.; see the Medicare Benefit Policy Manual, Chapter 16, §20 - Services Not Reasonable and Necessary. (Accessed January 14, 2019)
   d. Tobacco cessation counseling when tobacco dependency is the primary co-morbidity; See Guideline #2.e above.
   e. Services for inmates in a correctional institution; see the Medicare Benefit Policy Manual, Chapter 16, §50.3.1 - Application of Exclusion to State and Local Government Providers. (Accessed January 14, 2019)
   f. Services for members that are engaged in active military duty; see the Medicare Benefit Policy Manual, Chapter 16, §50.5 - Active Duty Members of Uniformed Services. (Accessed January 14, 2019)
   g. Services for which payment has been made or can reasonably be expected to be made promptly under a workers’ compensation law; see the Medicare Benefit Policy Manual, Chapter 16, §150 - Services Reimbursable Under Automobile, No Fault, Any Liability Insurance or Workers’ Compensation. (Accessed January 14, 2019)

**II. DEFINITIONS**

**Critical Care:** A physician’s (or physicians’) direct delivery of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single, or multiple, vital organ system failure; and/or to prevent further life threatening deterioration of the patient’s condition. Examples of vital organ system failure include (but are not limited to):
- Central nervous system failure;
- Circulatory failure; Shock;
- Renal, hepatic, metabolic, and/or respiratory failure.

Although it typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

You should remember that providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. While critical care is usually given in a critical care area such as a
coronary care unit, intensive care unit, respiratory care unit, or the emergency department, payment may also be made for critical care services that you provide in any location as long as this care meets the critical care definition.

When all these criteria are met, Medicare contractors (carriers and A/B MACs) will pay for critical care and critical care services that you report with CPT codes 99291 and 99292.

See the Medlearn Matters # 5993 Critical Care Visits and Neonatal Intensive Care. (Accessed January 14, 2019)

Non-Physician Practitioner (NPP): For Medicare purposes, the term non-physician practitioner (NPP) includes:
- Nurse practitioner or clinical nurse specialist, as those terms are defined in section 1861(aa)(5) of the Social Security Act, who is working in collaboration with the physician in accordance with State law
- Certified nurse-midwife, as defined in section 1861(gg) of the Social Security Act, as authorized by State law
- A physician assistant, as defined in section 1861(aa)(5) of the Social Security Act, under the supervision of the physician


Also see the following: Medicare Benefits Manual, Chapter 15, §180 - Nurse Midwife (CMN) Services
- Medicare Benefits Manual, Chapter 15, §190 - Physician Assistant (PA) Services
- Medicare Benefits Manual, Chapter 15, §200 - Nurse Practitioner (NP) Services
- Medicare Benefits Manual, Chapter 15, §210 - Clinical Nurse Specialist (CNS) Services

(Accessed January 14, 2019)

Physician: A doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.


III. REFERENCES

See above

IV. REVISION HISTORY

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)
Annual review with the following updates:

Guideline 1.a - added reference link to the “Medicare Benefits Manual, Chapter 15, §30.C - Consultations”.

Guideline 1.g [Home Visits (House Calls)] - updated LCD statement from: “Also refer to the Local Coverage Determinations (LCDs) for E & M and Domiciliary Visits at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.”
To “Local Coverage Determinations (LCDs) exist and compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.”

Guideline 1.i (Critical Care Visits and Neonatal Intensive Care Visits) - added reference link to the “Medicare Claims Processing Manual, Chapter 12, §30.6.12 - Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)”.

Guideline 2 - updated guideline title to: “Examples of other covered physician/practitioner services that are also covered.”

Updated Local Coverage Determination (LCD) Availability Grids; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)

Annual review with the following recommended update:

Guideline 1.d (Phone Consultation) - added cross reference link to the Coverage Summary for Telemedicine/Telehealth Services for coverage guideline for telemedicine services.

Re-review with the following recommended updates:

Guideline 2.g [Monitored Anesthesia Care (MAC)] -

- Removed the following language: “Services by a physician who performs “moderate” anesthesia in addition to a medical or surgical procedure in his/her office may bill separately for the anesthesia, e.g. surgeon who performs surgical anesthesia also performs the surgical procedure”

- Added the following language based from the “Medicare Claims Processing Manual, Chapter 12, §50.H - Monitored Anesthesia Care” and from the available Local Coverage Determinations (LCDs):

  “Payment for Anesthesiology Services - Monitored Anesthesia Care (MAC).

  MAC involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care.

  The A/B MAC pays for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services”

Guideline 2.h (Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services) - New to Coverage Summary and based
Definitions
Anesthesia, Moderate (conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accomplished by light tactile stimulation. - Deleted from definition section and moved to guideline 2.h.


02/14/2017 Annual review; no updates.
08/16/2016 Re-review with the following recommended update:
Guideline 1.g - Home Visits (House Calls)
- Deleted the following current coverage language from the Medicare Benefit Policy Manual (no longer included in the Medicare Benefit Policy Manual)
  • Home visits made by a physician to a member’s private residence may be covered when medically reasonable and necessary and not for the convenience of the physician or the member.
  • Although the member need not be confined to his home for the physician’s home visit services to be covered, the member’s condition must satisfy Medicare’s definition of ‘homebound”, and the medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.
  • Generally speaking, a patient will be considered to be “homebound” if he/she has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if leaving home is medically contraindicated.
- Added the following updated guideline from the Medicare Claims Processing Manual, Chapter 12 Physicians/Non-physician Practitioner, Section 30.6.14 - Home Care and Domiciliary Care Visits and Section 30.6.14.1 - Home Services (Codes 99341 - 99350) (Rev. 1, 10-01-03):
  Requirement for Physician Presence: Home services codes 99341-99350 are paid when they are billed to report evaluation and management services provided in a private residence. A home visit cannot be billed by a physician unless the physician was actually present in the beneficiary’s home.
  Homebound Status: Under the home health benefit the beneficiary must be confined to the home for services to be covered. For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

02/16/2016 Annual review; no updates.
03/24/2015 Annual Review with the following updates:
Guideline 1.a (General Coverage): Added reference link to the Medicare Benefits Manual, Chapter 15, Section 30 Physician
Guideline 1.b (Patient initiated Second Opinion): Added reference link to the Medicare
Guideline 1.c (Administration of injectable drugs and medications): Added reference link to the Medicare Benefits Manual, Chapter 15, Section 50.3 - Incident To Requirements


Guideline 1.e (Establishment and implementation of an appropriate treatment plan): Removed; specific CMS reference not found

Guideline 1.e (Concurrent Care): Added guideline based on Medicare Benefits Manual, Chapter 15, Section 30-E Concurrent

Guideline 1.f (Care Plan Oversight Services): Added guidelines based on Medicare Benefits Manual, Chapter 15, Section 30-G Care Plan Oversight Services

Guideline 1.g (Home Visits (House Calls)): Changed “provider” to “physician” based on Medicare Benefit Manual, Chapter 15, Section 30.6.14.1 Home Services (Codes 99341 - 99350)

Guideline 1.h (Phone Consultations): Added reference link to the Medicare Benefit Manual, Chapter 15, Section 30.B Telephone Services

Guideline 2.a (Physician services furnished in connection with dialysis sessions): Updated based on the Medicare Benefit Manual Chapter 11, Section 40 - Other Services

Guideline 2.b (Physician services for surgery, childbirth and treatment of infertility): Added reference link to the Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services §20.1 Physician Expense for Surgery, Childbirth, and Treatment for Infertility

Guideline 2.c (Physician services for treatment of allergies): Added reference link to the Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services, Section 20.2 - Physician Expense for Allergy Treatment

Guideline 2.d (Podiatric and chiropractic physician services): Added reference link to the Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services, Section 30.5 - Chiropractor’s Services

Guideline 2.e (Tobacco cessation counseling): Deleted reference to ICD-9 code 305.1; Added reference link to the NCD for Counseling to Prevent Tobacco Use (210.4.1)

Guideline 2.f (Coumadin (anti-coagulation) monitoring): Added reference link to the Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services, Section 60.3 - Incident To Physician’s Services in Clinic

Guideline 2.g (Services by a physician who performs “moderate” anesthesia): Removed “or a psychiatrist’s performance of anesthesia services associated with electroconvulsive therapy”; Added reference link to the Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 50-L Anesthesia and Medical/Surgical Service Provided by the Same Physician

Guideline 3.a (Treatment for any illness or injury when not attended by a licensed physician, surgeon, or healthcare professional): Added reference link to the Medicare Benefits Manual, Chapter 15, Section 30-D Patient Initiated Second Opinion
Guideline 3.b (Services that are oriented toward treating a social, developmental or learning problem as opposed to a medical problem): Removed; specific CMS reference not found

Guideline 3.c (Outpatient take home medications): Removed; specific CMS reference not found

Guideline 3.d (Employer requests for clearance to work or documentation as a reason for missed work): Re-numbered to 3.b; Added reference link to the Medicare Benefit Policy Manual, Chapter 16 General Exclusions from Coverage, Section 20 - Services Not Reasonable and Necessary

Guideline 3.e (Completion of forms): Re-numbered to 3.c; Added reference link to the Medicare Benefit Policy Manual, Chapter 16 General Exclusions from Coverage, Section 20 - Services Not Reasonable and Necessary

Guideline 3.f (Tobacco cessation counseling): Re-numbered to 3.d

Guideline 3.g.1 (Services for inmates in a correctional institution): Re-numbered to 3.e; Added reference link to the Medicare Benefit Policy Manual, Chapter 16 General Exclusions from Coverage, Section 50.3.1 Application of Exclusion to State and Local Government Providers

Guideline 3.g.2 (Services for members that are engaged in active military duty): Re-numbered to 3.f; Added reference link to the Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage, Section 50.5 - Active Duty Members of Uniformed Services

Guideline 3.g.3 (Services for workers’ compensation): Re-numbered to 3.g; Added reference link to the Medicare Benefit Policy Manual, Chapter 16 - General Exclusions from Coverage, Section 150 Services Reimbursable Under Automobile, No Fault, Any Liability Insurance or Workers’ Compensation

Definitions

- Updated the definitions of:
  - Anesthesia, Moderate (added referenced link to the Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 50-L Anesthesia and Medical/Surgical Service Provided by the Same Physician)
  - Critical Care (added referenced link to the Medlearn Matters #5993 Critical Care Visits and Neonatal Intensive Care)

- Removed the definition of:
  - Direct Supervision (not addressed in the coverage summary)
  - Provider (not addressed in the coverage summary)

- Updated the definition of:
  - Non-Physician Practitioner (NPP) [based on the Palmetto GBA Article “Who Qualifies as a Non-physician Practitioner (NPP) and the Medicare Benefits Manual, Chapter 15 Sections 180 Nurse Midwife (CMN) Services, 190 Physician Assistant (PA) Services, 200 Nurse Practitioner (NP) Services, and 210 Clinical Nurse Specialist (CNS) Services]
  - Physician (based on the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §70 Physician Defined)
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.

V. ATTACHMENT

Attachment A - LCD Availability Grid

Monitored Anesthesia Care

CMS website accessed November 6, 2019

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End of Attachment A