# Coverage Summary

## Physician Services

<table>
<thead>
<tr>
<th><strong>Policy Number:</strong></th>
<th>P-005</th>
<th><strong>Products:</strong></th>
<th>UnitedHealthcare Medicare Advantage Plans</th>
<th><strong>Original Approval Date:</strong></th>
<th>08/28/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approved by:</strong></td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td><strong>Last Review Date:</strong></td>
<td>02/18/2020</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Medicare Advantage Policy Guideline:** Counseling to Prevent Tobacco Use (NCD 210.4.1)

---

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).

## INDEX TO COVERAGE SUMMARY

<table>
<thead>
<tr>
<th><strong>I. COVERAGE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Coverage</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3. Examples of Non-Covered Services</td>
</tr>
</tbody>
</table>
I. COVERAGE

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

Guidelines/Notes:

1. Coverage

Reasonable and necessary physician/practitioner services are covered. Professional services of the physician are covered if provided within the United States, and may be performed in a home, office, institution, or at the scene of an accident. A patient’s home, for this purpose, is anywhere the patient makes his or her residence, e.g., home for the aged, a nursing home, a relative’s home. (See the Definitions Section below)


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


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 29, 2020)

b. Patient-initiated second opinions; 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 29, 2020)


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

e. 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 physician rendering concurrent care could be covered where 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 is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.


---

f. Care plan oversight is supervision of patients under care of home health agencies or hospices 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.

maintenance dialysis in an ESRD facility or at home; see the Medicare Benefit Manual, Chapter 11, §40 – Other Services. (Accessed January 29, 2020)


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


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.

n. Smoking and Tobacco Use Cessation Counseling

Tobacco cessation counseling, through the treating physician, when a member has a disease or an adverse heath 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 29, 2020)

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

o. 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 29, 2020)

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

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.


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).

q. 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.


r. 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 29, 2020)
   
   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 29, 2020)
   
   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 29, 2020)
   
   d. Tobacco cessation counseling when tobacco dependency is the primary co-morbidity; See Guideline #2.n 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 29, 2020)
   
   Also see the Coverage Summary for Services While Confined/Incarcerated.
   
   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 29, 2020)
   
   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 29, 2020)

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 29, 2020)

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

(Please visit the above links for more detailed information.)

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

02/20/2020  Guideline 1 (Coverage)
• Added language to indicate:
  o Professional services of the physician are covered if provided within the United States, and may be performed in a home, office, institution, or at the scene of an accident
  o A patient’s home, for this purpose, is anywhere the patient makes his or her residence, e.g., home for the aged, a nursing home, a relative’s home

Guideline 2 (Examples of Physician/Practitioner Services that are Covered)
• Updated list of examples of covered physician/practitioner services (relocated from Guideline 3); added:
  o Physician services furnished in connection with dialysis sessions
  o Physician services for surgery, childbirth and treatment of infertility
  o Physician services for treatment of allergies
  o Chiropractic physician services
  o Smoking and tobacco use cessation counseling
  o Coumadin (anti-coagulation) monitoring
  o Monitored anesthesia care (MAC)
  o Moderate sedation services furnished in conjunction with and in support of procedural services
  o Telephone transmission of EEGs

Guideline 2.b (Patient-Initiated Second Opinions)
• Removed detailed coverage guidelines [duplicative to the language outlined in the referenced UnitedHealthcare Medicare Advantage Coverage Summary titled Second and Third Opinions]

Guideline 2.g (Home Services)
• Changed guideline title; previously titled Home Visits (House Calls)

Guideline 2.m (Chiropractic Physician Services)
• Changed guideline titled; previously titled Podiatric and Chiropractic Physician Services
  o Removed reference link to the Medicare Benefit Policy Manual, Chapter 15, §30.5 – Chiropractor’s Services

Guideline 2.q (Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services)
• Removed language pertaining to moderate sedation provided by the same [or] physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports
• Updated list of applicable CPT codes; removed 99151, 99152, 99153, 99155, 99156, 99157 and G0500

Guideline 3 (Examples of Other Covered Physician/Practitioner Services)
• Removed/relocated content (refer to Guideline 1)
V. ATTACHMENT

Attachment A-LCD Availability Grid

**Monitored Anesthesia Care**

CMS website accessed January 29, 2020

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L35049</td>
<td>Monitored Anesthesia Care</td>
<td>MAC-Part A and B</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, DC, DE, CO, LA, MD, MS, NJ, NM, OK, PA, TX</td>
</tr>
</tbody>
</table>

End of Attachment A