

# Physician Services

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[Instructions for Use](#)

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Related Medicare Advantage Policy Guideline

- [Counseling to Prevent Tobacco Use \(NCD 210.4.1\)](#)

## Coverage Guidelines

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

### Coverage Criteria

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. (Refer to the [Definitions](#) section)

Refer to the [Medicare Benefits Manual, Chapter 15, §30.A – Physician Services General](#). (Accessed February 8, 2021)

### Covered Physician/Practitioner Services

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

#### *Diagnosis, Therapy, Surgery, and Consultation Rendered by a Licensed Provider*

Refer to the [Medicare Benefits Manual, Chapter 15, §30.A – Physician Services General](#). (Accessed February 8, 2021)

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.

Refer to the [Medicare Benefits Manual, Chapter 15, §30.C – Consultations](#). (Accessed February 8, 2021)

For detailed coding information regarding this change, refer to the [Medicare Claims Processing Manual, Chapter 12, §30.6.10 – Consultation Services](#). Also refer to §190.3 for telehealth services. (Accessed February 8, 2021)

#### *Patient-Initiated Second Opinions*

Refer to the Coverage Summary titled [Second and Third Opinions](#).

## ***Administration of Injectable Drugs and Medications***

Administration of injectable drugs and medications in the physician's office as routine part of the medical office visit; refer to the [Medicare Benefits Manual, Chapter 15, §50.3 – Incident To Requirements](#). (Accessed February 8, 2021)

## ***Preventive Health Examinations***

Refer to the [Medicare Benefits Manual, Chapter 15, §280 – Preventive and Screening Services](#). (Accessed February 8, 2021)  
Also refer to the Coverage Summary titled [Preventive Health Services and Procedures](#).

## ***Concurrent Care***

Concurrent care exists where more than one physician renders services more extensive than consultative services during a period. 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.

Refer to the [Medicare Benefits Manual, Chapter 15, §30.E – Concurrent Care](#). (Accessed February 8, 2021)

## ***Care Plan Oversight***

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.

For specific coverage requirements, refer to the [Medicare Benefits Manual, Chapter 15, §30.G – Care Plan Oversight Services](#). (Accessed February 8, 2021)

## ***Home Services***

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.

Refer to the [Medicare Claims Processing Manual, Chapter 12, §30.6.14-Home Care and Domiciliary Care Visits and §30.6.14.1 – Home Services \(Codes 99341-99350\)](#). (Accessed February 8, 2021)

Also refer to the [Medicare Benefit Policy Manual, Chapter 7, §30.1 – Patient Confined to the Home](#). (Accessed January 29, 2020)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for E&M home and domiciliary visits exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&>.

## ***Physician Consultations by Phone***

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, refer to the Coverage Summary titled [Telemedicine/Telehealth Services](#).)

Refer to the [Medicare Benefit Manual, Chapter 15, §30.B – Telephone Services](#). (Accessed February 8, 2021)

### ***Physicians and Non-Physician Practitioners (NPPs)***

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](#). (refer to [Definitions](#) section)

Refer to the [MLN Matters # 5993 Critical Care Visits and Neonatal Intensive Care](#). (Accessed February 8, 2021)

Also refer to the [Medicare Claims Processing Manual, Chapter 12, §30.6.12 – Critical Care Visits and Neonatal Intensive Care \(Codes 99291-99292\)](#). (Accessed February 8, 2021)

### ***Physician Services Furnished in Connection with Dialysis***

Physician services furnished in connection with dialysis sessions for outpatients who are on maintenance dialysis in an ESRD facility or at home; refer to the [Medicare Benefit Manual, Chapter 11, §40 – Other Services](#). (Accessed February 8, 2021)

### ***Physician Services for Surgery, Childbirth and Treatment of Infertility***

Refer to the [Medicare Benefit Policy Manual, Chapter 15, §20.1 – Physician Expense for Surgery, Childbirth, and Treatment for Infertility](#). (Accessed February 8, 2021)

Also refer to the Coverage Summaries titled [Maternity and Newborn Care](#) and [Infertility Services](#).

### ***Physician Services for Treatment of Allergies***

Refer to the [Medicare Benefit Policy Manual, Chapter 15, § 20.2 – Physician Expense for Allergy Treatment](#). (Accessed February 8, 2021)

Also refer to the Coverage Summary titled [Allergy Testing and Allergy Immunotherapy](#).

### ***Chiropractic Physician Services***

Refer to the Coverage Summary titled [Chiropractic Services](#)

### ***Smoking and Tobacco Use Cessation Counseling***

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.

Refer to the [NCD for Smoking and Tobacco Use Cessation Counseling \(210.4\)](#) and [NCD for Counseling to Prevent Tobacco Use \(210.4.1\)](#). (Accessed February 8, 2021)

Also refer to the Coverage Summary titled [Preventive Health Services and Procedures](#).

### ***Coumadin (Anti-Coagulation) Monitoring***

Coumadin (anti-coagulation) monitoring performed at a free-standing clinic or a clinic within a hospital or that is attached to a hospital; refer to the [Medicare Benefit Policy Manual, Chapter 15, §60.3 – Incident To Physician's Services in Clinic](#). (Accessed February 8, 2021)

### ***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.

Refer to the [Medicare Claims Processing Manual, Chapter 12, §50.H – Monitored Anesthesia Care](#). (Accessed February 8, 2021)

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 table for [Monitored Anesthesia Care](#).

### ***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.

For additional information, refer to the [Medicare Claims Processing Manual, Chapter 12, §50.J – Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services](#). (Accessed February 8, 2021)

### ***Telephone Transmission of EEGs***

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.

Refer to the [NCD for Telephone Transmission of Electroencephalograms \(EEGs\) \(160.21\)](#). (Accessed February 8, 2021)

### **Non-Covered Physician/Practitioner Services**

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

- Treatment for any illness or injury when not attended by a licensed physician, surgeon, or healthcare professional; refer to the [Medicare Benefits Manual, Chapter 15, §30 – Physician Services](#). (Accessed February 8, 2021)
- Employer requests for clearance to work or documentation as a reason for missed work; refer to the [Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary](#). (Accessed February 8, 2021)
- Completion of forms, e.g., insurance, employment, school, sports, summer camp, Department of Motor Vehicle (DMV), etc...; refer to the [Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary](#). (Accessed February 8, 2021)
- Tobacco cessation counseling when tobacco dependency is the primary co-morbidity; Refer to [Smoking and Tobacco Use Cessation Counseling](#) section.
- Services for inmates in a correctional institution; refer to the [Medicare Benefit Policy Manual, Chapter 16, §50.3.1 – Application of Exclusion to State and Local Government Providers](#). (Accessed February 8, 2021)  
Also refer to the Coverage Summary titled [Services While Confined/Incarcerated](#).
- Services for members that are engaged in active military duty; refer to the [Medicare Benefit Policy Manual, Chapter 16, §50.5 – Active Duty Members of Uniformed Services](#). (Accessed February 8, 2021)

- Services for which payment has been made or can reasonably be expected to be made promptly under a workers' compensation law; refer to the [Medicare Benefit Policy Manual, Chapter 16, §150 – Services Reimbursable Under Automobile, No Fault, Any Liability Insurance or Workers' Compensation](#). (Accessed February 8, 2021)

## 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.

Refer to the [MLN Matters # 5993 Critical Care Visits and Neonatal Intensive Care](#). (Accessed February 8, 2021)

**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

Refer to the Palmetto GBA Article "Who Qualifies as a Non-physician Practitioner (NPP)" at <http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~JM Home Health and Hospice~Resources~FAQs~Home Health~8GKMQC6571?open&navmenu=%7C%7C>. (Accessed February 8, 2021)

Also refer to 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 February 8, 2021)

**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.

Refer to the [Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §70 – Physician Defined](#).  
(Accessed February 8, 2021)

## Supporting Information

**Important Note:** When searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

Monitored Anesthesia Care Accessed February 8, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L35049 (A57361)	<a href="#">Monitored Anesthesia Care</a>	Part A and B MAC	Novitas Solutions, Inc.	AR, DC, DE, CO, LA, MD, MS, NJ, NM, OK, PA, TX
<a href="#">Back to Guidelines</a>				

## Policy History/Revision Information

Date	Summary of Changes
05/01/2021	<b>Template Update</b> <ul style="list-style-type: none"><li>Reformatted policy; transferred content to new template</li></ul>
02/16/2021	<ul style="list-style-type: none"><li>Routine review; no change to coverage guidelines</li></ul>

## Instructions for Use

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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 are 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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