8-25-25 Weekly Clinical Update

An interesting subject has been involved in several phone calls in the past couple of weeks related to physician visits. Two particular questions came up: 1. Do physician visits have to be "in-person"? and 2. "Are there any rules about timeliness of the physician returning documentation of visits to the facility?" These issues are not likely to be pertinent only to the facility staff that asked the questions. They are probably issues that others have faced also. So let's delve into the issue…(HINT: admission & routine chart audits are a MUST for compliance…for multiple reasons!)

Visit Frequency Requirements

According to CMS guidelines:

- Initial Visit: Each resident must be seen by a physician within the first 30 days of admission.
- First 90 Days: Residents must be seen at least once every 30 days.
- Ongoing Care: After the first 90 days, visits must occur at least once every 60 days.
- Timeliness Buffer: A visit is considered timely if it occurs within 10 days of the required date.

Delegation to Non-Physician Practitioners (NPPs)

- The initial comprehensive visit in a Skilled Nursing Facility (SNF) cannot be delegated to an NPP.
- In Nursing Facilities (NFs), subsequent visits may be conducted by NPPs not employed by the facility, provided they work in collaboration with a physician and are licensed under state law.
- NPPs employed by the facility may conduct medically necessary visits, but these do not count toward the required physician visit schedule.

Documentation Requirements

To ensure compliance and support billing, documentation must be:

- Legible, dated, and signed by the treating physician or NPP.
- Include a progress note or Evaluation & Management (E/M) note that supports medical necessity and the level of service billed.
- Clearly reflect that a face-to-face visit occurred.
- Include:
    - Chief complaint and history (with notation if taken by ancillary staff).
    - Physical exam findings.
    - Medical decision-making rationale.
    - Orders or intent to order services.
    - Diagnostic test results, if applicable.

- Time spent on counseling or coordination of care, if used to justify E/M level

Common Pitfalls

- Missing documentation of required visits within the specified timeframes.
- Late entries without clear justification.
- Inadequate detail in progress notes, especially for acute changes or behavioral symptoms.
- Failure to distinguish between required visits and medically necessary but non-scheduled visits.

Best Practices for Facilities

- Provide physician/NPP access to EMR and require they use the facility's EMR for documentation of visits and consults
- Use automated alerts in EMRs to flag upcoming visit deadlines then designate (Med Records?) to make contact reminders.
- Maintain a physician visit tracker aligned with admission dates and regulatory timelines.
- Implement audit tools to verify documentation completeness and timeliness.
- Provide training modules for physicians and NPPs on documentation standards and CMS expectations.
- Ensure interdisciplinary communication so that changes in condition prompt timely evaluations.
- Audit EMR entries to confirm that location and modality of the visit are clearly documented by the practitioner

When are Telehealth visits allowable?

- According to CMS regulations under 42 CFR §483.30(c), for both Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs), the mandated physician visits—such as the initial comprehensive visit and the periodic 30-/60-day visits—must involve face-to-face contact at the same physical location. These cannot be conducted via telehealth.
- Key Definitions:
    - "Must be seen" means the physician (or qualified NPP, where allowed) must make actual face-to-face contact with the resident.
    - Telehealth visits do not satisfy the regulatory requirement for these scheduled visits.
- What About Medically Necessary Visits?

- Medically necessary visits outside the required schedule may be conducted via telehealth if permitted by facility policy.
- These visits can be performed by non-physician practitioners (NPPs) such as nurse practitioners or physician assistants, but they do not count toward the required visit schedule unless specific delegation rules are met.

- **Physician Progress Note Timeliness in Nursing Homes**

Physicians are expected to document their visits promptly to ensure continuity of care, regulatory compliance, and accurate billing. While CMS does not specify an exact number of hours, best practices and guidance from organizations like AMDA (The Society for Post-Acute and Long-Term Care Medicine https://old.paltc.org/about-amda) recommend that:

- Progress notes should be entered into the resident's medical record within 24 hours of the visit.
- This timeframe supports:
    - Timely interdisciplinary review and care planning
    - Accurate medication and treatment orders
    - Survey readiness and defensible documentation for audits
- Facility "Best Practices"
    - Use EMR alerts to flag missing or late documentation
    - Include progress note timeliness in physician contracts or on-boarding materials
    - Audit (Medical Records?) physician documentation weekly to catch delays before they become deficiency citations.