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Internal Medicine Coding Alert

3 Scenarios Improve Your Nursing-Home Coding

Knowing the documentation requirements makes all the difference

From admissions and re-evaluations to changes in status, coding nursing facility services can easily become one of your biggest headaches. But you can submit your claims with confidence if you correctly code these real-world case studies.

Document the Initial Plan of Care

1. Scenario: The internist readmits a patient back into the nursing home a couple of months after the home discharged her. He performs an assessment, which includes evaluating the patient's diabetes (250.83), scoliosis (737.39) and hypertension (401.x). The internist documents the patient and her family's medical history. Also, he prescribes medications and plans a course of treatment. Overall, the visit takes about 50 minutes.

Best bet: You should report this visit as 99303 (Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission ...), as long as the physician's documentation supports the service, says **Patti Merdian, CPC, CCS, CCS-P,** regional director of client services with Bill Dunbar and Associates in Indianapolis.

For instance, if time is not the determining factor for 99303, your documentation must meet the minimum requirements of a comprehensive history, a comprehensive exam and medical decision-making of moderate to high complexity, Merdian says.

"The physician does have to do an initial medical plan of care," which he should document, says **Jean Ryan-Niemackl, LPN, CPC,** a coding specialist in Fargo, N.D., who gave a teleconference on reporting and documenting nursing-home visits for The Coding Institute. For example, in the above scenario, the physician's plan of care would involve treatment and evaluation for the patient's diabetes, scoliosis and hypertension.

Potential problem: IM coders often struggle with justifying 99303's medical decision-making component. That's because another physician sometimes writes a patient's admitting orders, and the internist follows the patient and reviews the orders.

Your solution: The key is to document the complexity and number of conditions the internist will be treating, Ryan-Niemackl says. For example, if the doctor prescribes medication to treat three separate conditions, that should qualify as moderate medical decision-making, she adds.

Remember That All Physicals Aren't Routine

2. Scenario: The internist performs an annual assessment of a nursing-home patient. This includes the physician documenting the chief complaint, extended history of present illness, and a review of eight of the nine body systems. The doctor also reviews and affirms the medical plan of care.

What to do: For a typical yearly physical, which requires a detailed interval history, a comprehensive exam and straightforward decision-making, you should list 99301 (Evaluation and management of a new or established patient involving an annual nursing facility assessment ...), Merdian says.

Note: If you're following Medicare's 1995 E/M guidelines, the physician's review of eight body systems will meet documentation requirements. But when you follow the 1997 guidelines, the physician must review at least nine organ systems, with two assessments for each of those systems to satisfy documentation requirements, Merdian says.

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In addition to satisfying all three history, exam and straightforward decision-making requirements, be sure the physician also reviews the medical plan of care, Ryan-Niemackl adds.

Caution: Don't confuse this visit with a routine physical, Ryan-Niemackl says. "In the routine physical, obviously the patient does not have any complaints or problems, and that would not be the case with nursing-home patients. ... Patients in nursing homes always have problems, otherwise why would they be there?"

Use New Illness to Pick 99302 or 99313

3. Scenario: Your internist wants to bill 99313 (Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient ...) for managing the care of a patient who recently had a stroke. The doctor had already been caring for the patient's arterial sclerosis and diabetes.

In the documentation, the physician states he recorded a chief complaint (the stroke), took a history of present illness (arterial sclerosis and diabetes) and reviewed multiple body systems, including cardiovascular, neurological, respiratory and the ears, nose, throat and mouth. The decision-making is of moderate complexity.

Time to educate: To prevent a denial for this visit, you should talk with your physician about reporting code 99302 (Evaluation and management of a new or established patient involving a nursing facility assessment ...) instead of 99313. This code describes subsequent-care services. Your best bet is to list 99302, because the patient had a stroke, which changes the patient's status, Ryan-Niemackl says.

"You use code 99302 when the patient has had this significant new problem and has a major permanent change in his or her status," she says.

Tip: When reporting 99302, be sure your physician developed and documented a new medical plan of care, Ryan-Niemackl adds.

Editor's note: For more information on The Coding Institute's teleconferences, please call (800) 508-2582, or visit www.codinginstitute.com.

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