# Internal Medicine Coding Alert

## Are You Coding Home-Health Services Correctly? Find Out

**Why you should list the patient's comorbidities**

You can correctly code the internist's home-health and care-plan-oversight services if you understand that Medicare and private payers require different codes, and if the physician documents the treatment plan and time spent supervising the care.

**Best bet:** Use the scenario below to learn the right codes to use and what documentation you'll need to get paid every time.

**How to Report the Initial Plan**

**Scenario:** Your internist is managing a 67-year-old woman on Medicare. After she suffers congestive heart failure (428.0, Congestive heart failure, unspecified), she undergoes coronary artery bypass surgery. The woman's existing conditions include diabetes (250.xx), severe obesity (278.01) and chronic simple glaucoma (365.11, Primary open angle glaucoma). To monitor the patient's potential complications following her discharge from the hospital, the internist develops a home-health plan of care.

**What to Document**

1. Your physician should note the number of times a week he wants the home-health agency to visit the patient, says **Trish Bukauskas-Vollmer, CMM, CPC, CMSCS**, president and CEO of TB Consulting in Myrtle Beach, S.C. For example, he may want the home-health nurse to see the patient twice a week for a month, and then once a week for the next six weeks.

2. Your internist should document reviews of subsequent patient status reports, related lab work and other studies, the patient's medications, and discussions with other health professionals who are not employed in the same practice. Also, note any adjustment to the patient's medical treatment plan, diet or medical therapy, Bukauskas-Vollmer says.

**Your HCPCS choice:** Because the patient is on Medicare, you can report G0180 (Physician certification for Medicare-covered home health services under a home health plan of care [patient not present], including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period) for the care plan, which the physician should have signed and initiated, Bukauskas-Vollmer says.

If you use G0180, be sure the patient hasn't had home health services within the last 60 days, says **Pat Larabee, CPC, CCP**, a coding specialist at InterMed, a multispecialty healthcare network in South Portland, Maine.

**Bonus tip:** When billing G0180, use the "Start of Care" date to avoid denials if you later bill for recertification of treatment plan (G0179), she says.

**Let Secondary Codes Support Necessity**

As your primary diagnosis code for the home-health certification, you should list 428.0 for the patient's congestive heart failure. But don't stop there. You should also report the comorbidities, such as 250.xx (diabetes), 278.01 (severe obesity) and 365.11 (chronic simple glaucoma).

Listing all of the patient's conditions helps the payer understand the necessity for the home-health treatment,

Bukauskas-Vollmer says.

**Note:** Most private payers won't accept G0180, so contact your insurer to find out how to bill the service.

**Get Ready to Code CPO Supervision**

When the internist alters the treatment plan, you can report this service if he documents the time.

For instance, during the first month of the patient's home-health treatment, your internist changes the patient's blood-pressure medication and modifies the care plan so the home-health nurse will increase the number of weekly visits.

**Medical notes:** Your internist documents that, within that first calendar month, he spent five minutes reviewing the patient's status, 15 minutes reviewing the patient's electrocardiogram (EKG), 10 minutes reviewing lab tests, and 10 minutes discussing the care plan with the patient's cardiologist. Also, he documents the EKG and lab tests' results and the cardiologist's recommendation for care.

**Coding choice:** Because the physician documented more than 30 minutes of supervision within a calendar month, you could report G0181 (Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency [patient not present] requiring 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 [including telephone calls] with other healthcare professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more) to Medicare, Bukauskas-Vollmer says.

In this instance, if the patient had private insurance, you could use 99375 (Physician supervision of a patient under care of home health agency [patient not present] in home, domiciliary or equivalent environment [e.g., Alzheimer's facility] ... within a calendar month; 30 minutes or more).

Remember that the internist doesn't have to provide the 30 minutes of supervision all at one time, Bukauskas-Vollmer says. "It could be five minutes today and 10 minutes tomorrow," she adds. Also, the physician who bills for the supervision codes must be the same physician who originally initiated the CPO with the home-health agency.

**Another tip:** Be sure the physician doesn't count the following services in the 30 minutes, Bukauskas-Vollmer says:

1. Discussions with the patient

2. Communication with the patient's family or friends

3. Staff obtaining charts

4. Travel time if the physician visits the patient

5. Time spent telephoning prescriptions to the pharmacist. The only exception to this one is if the physician has to call the pharmacy because of medical necessity. For instance, if the physician called because of an allergic reaction or if he was worried about a contraindication, Bukauskas-Vollmer says.

**Understand Recertification Coding Requirements**

If the internist recertifies the patient's treatment plan, here's how to ensure he gets paid for that work:

**Scenario:** After discussions with the home-health agency and reviews of the patient's status reports, the internist determines that the patient should remain on the home-health treatment plan longer than 60 days.

Therefore, the physician bills for a plan recertification. You report G0179 (Physician recertification for Medicare-covered

home health services under a home health plan of care [patient not present], including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per recertification period) to Medicare. Private carriers may have different coding requirements for recertifications, so check with your insurer.

**Good idea:** To prevent denials for G0179, be sure the documentation shows that 60 days have elapsed from the time you reported the initial certification or Medicare payers will deny your claim, Larabee says.