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Internal Medicine Coding Alert

Documentation and Correct Coding are Key to Reimbursement for Home Visits by the Internist

More and more internal medicine physicians, particularly those who are their patients primary-care providers, are making home visits a part of their practicesometimes as a convenience to the patient and sometimes out of clinical necessity. Reporting these services in compliance with CPT and Medicare guidelines can be tricky, but documentation and correct coding will help with payment.

Would you please let me know what CPT code I have to use for a visit (procedure) for seeing a patient at home? writes **S. Moss, MD,** a subscriber in Los Angeles, CA. I have three patients who are not able to come to my office. One has multiple sclerosis, one has congestive heart failure, and one has hypertension and severe anemia since January. Medicare keeps denying every service, including blood drawing and handling, visits, and blood pressure.

Medicare coding rules will differ depending on the type of visit and procedure performed, notes **Cynthia Thompson, CPC,** senior coding consultant with Gates, Moore, and Co., an Atlanta, GA-based accounting firm.

For example, is the physician making the visit to the patient? Or, is a nurse from the practice going out to perform routine checks on blood pressure, drawing blood for lab tests, etc.

Coding for Home Visits

CPT codes 99341-99345 and 99347-99350 (home services) should be used to report home visits by the internist. Codes 99341-99345 are for new patients, and codes 99347-99350 are for established patients. According to CPT, these codes are used to report evaluation and management services provided in a private residence. For definitions of the key components and commonly used terms, please use the Evaluation and Management Services Guidelines.

These codes are commonly used by home health providers, but can be used by physicians who see patients at home, notes Thompson. You should be careful to indicate the correct place of service on the bill (private residence), along with the CPT code for home services.

Like the office/outpatient E/M codes used for office visits (99201-99205, new patient; and 99211-99215, established patient), the physician must accurately document the level of history, physical exam and medical decision-making provided in order for a coder to assign the correct level of home services code.

In addition, Medicare does limit payment for home services to only those patients whose medical condition necessitates treatment at home instead of the physicians office, says **Emily Hill, PA-C,** president of Hill and Associates, a medical practice management and coding consulting firm in Southport, NC. But, it does sound like the patients this physician is treating meet those criteria. The conditions described should warrant home treatment.

Diagnoses Codes are Crucial

In addition to using the correct CPT code, the practice should make sure the correct ICD-9 diagnosis code is used to reflect the medical necessity of the home visit, adds Thompson. If the physician has used the home services CPT codes as well as diagnosis codes that accurately reflect the patients medical condition and reason for the visit, the service should be paid. Thompson recommends checking with the carrier regarding medical necessity requirements if the visits continue to be denied.

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Note: The above instructions assume that the physician, physician assistant or nurse practitioner is providing the home service. A nurse cannot provide home services to patients incident to the physician service without the physicians physical presence.

Blood Pressure Checks and Blood Draws

Typically, services like follow-up blood pressure checks and blood draws for lab tests are performed in the physicians office, without physician supervision, and are usually reported with the office/outpatient E/M code 99211. This code is the only CPT code that does not require a specific level of history, exam or medical decision-making.

However, Medicare has special rules for these
services performed at a private residence.

Medicare considers that intermittent services like blood drawing and handling, venipunctures and injections should be performed by a home-health nurse, Hill says. Carriers have rules prohibiting payment to the physician unless home health is unavailable in that area.

In Los Angeles, it is highly likely that a home-health agency would be available to provide these services to patients. However, if the patients internist felt that the home health agency would not be able to provide adequate services to the patient, or there were, indeed, no available home health agency, then the physician could appeal to the carrier to provide these services from his or her office.

After appealing for a home-health exception, the internist should check with the carrier on which code should be used to report these services.

Note: If the physician performed a blood draw to obtain a sample for lab work at the same time as an E/M visit, then the physician might be able to report code 36415* (routine venipuncture). This code is a starred (*) procedure in CPT and, according to CPT rules, includes only the surgical service and no evaluation and management services.

However, Medicare has separate rules regarding surgical services and probably will not pay a blood draw separately. Blood pressure checks, if performed at the same time as an E/M service, would be included in the E/M code.

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