

Internal Medicine Coding Alert

Tips for Properly Coding Nursing Home and Assisted Living Center Visits

Visits to long-term-care facilities can present coding challenges even to experienced physicians and coders. The keys to coding the internist's visit correctly are to know:

the purpose of the internist's visit (admission, readmission, annual assessment or other visit)
the nature of the presenting problem (patient stable or recovering, has minor complication or has major complication)
the location of the patient (skilled nursing/nursing facility or assisted living center).

This information will help you determine the correct E/M series, the proper E/M code in that series, and the appropriate place-of-service code.

Nursing Home: Admission, Readmission and Annual Assessment

Many coders assume that the comprehensive nursing facility assessment codes (99301-99303) are configured the same way as the outpatient E/M series (99201-99215), with each code reflecting an increasing level of complexity. However, these codes are designed to report three different services: the patient's admission or readmission to the nursing facility, the annual assessment required for all patients in nursing homes, and the physician's reassessment of the patient after a new problem develops that necessitates a new medical care plan.

When the patient is first admitted to the nursing home and a medical plan of care is created, report 99303 (Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires a comprehensive history and examination, and medical decision making of moderate to high complexity).

This code is also used if the patient is readmitted to the nursing home after being discharged. If that readmission is for the same medical problem and occurs within 30 days of discharge, however, the claim may be rejected by Medicare, says **Judy Richardson, RN, MSA, CCS-P**, a senior consultant at Hill and Associates, a consulting firm in Wilmington, N.C., that works with physician practices on coding and compliance. If the claim is rejected, appeal and ask for review because this is the code Medicare specifies for readmissions, says Richardson.

To report the annual assessment of the patient, use 99301 (Evaluation and management of a new or established patient involving an annual nursing facility assessment, which requires a detailed interval history; a comprehensive examination; and medical decision making that is straightforward or of low complexity). This is the required yearly visit, where the physician reviews and recertifies the resident's care plan. The CPT manual notes that when this code is used, "usually, the patient is stable, recovering or improving."

When the patient develops a complication or new problem that requires development of a new care plan, report 99302 (... a detailed interval history, a comprehensive examination; and medical decision making of moderate to high complexity). The least-used of the three codes is 99302. It's appropriate to use, for example, when a patient who is in the nursing home for rehabilitation after hip surgery has a stroke. The CPT manual states: "Usually the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan is required."

"The key point to note in the description is that there is 'a major permanent change in status' that requires development of a new medical care plan," says **Jean Ryan-Niemackl, LPN, CPC**, compliance analyst for MeritCare Health Systems, a multispecialty system in Fargo, N.D., that includes clinics, hospitals and physicians.

Coding Subsequent Visits to Nursing Home

Use 99311-99313 when the doctor visits the nursing home for follow-up visits. These codes are for regular checkups. (Medicare requires one visit by the physician every 30 days for the first three months and one visit every 60 days after that.) These codes are also for problem visits for both new and established patients.

While the key components are mandatory in code selection, Ryan-Niemackl says coders should be careful to read the entire definition of these codes in the CPT manual. The last paragraph of each section, which describes the nature of the presenting problem and the typical amount of time spent by the physician, is as valuable in the selection process as the key components.

When the patient is "stable, recovering or improving," the CPT manual says, the coder should use 99311 (Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity). Code 99311 should not be reported when several visits are made to a patient within a few weeks. "If you use this particular code more than once a month, chances are Medicare is going to say, 'If this patient is that stable, why are you going back more than once a month?'" Richardson says.

When a patient is not recovering or is seen for a complication for example, influenza (487.1, Influenza with other respiratory manifestations), and the physician documents the patient's fever, congestion and other evidence supporting the diagnosis of influenza 99312 (an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity) should be coded. For 99312 to apply, "usually the patient is responding inadequately to therapy or has developed a minor complication," the CPT manual says.

"The coder has to be careful to read what the physician puts in his documentation," says Ryan-Niemackl. If the physician's notes state the patient is doing well or is stable, recovering or improving, the documentation will not support the nature of the presenting problem for 99312.

When the patient has a problem that is serious but does not require hospital admission, code 99313 (a detailed interval history; a detailed examination; medical decision making of moderate to high complexity). "Usually, the patient has developed a significant complication or a significant new problem," the CPT manual says. Richardson recommends using 99313 when the patient with influenza in the example above is also diagnosed with pneumonia (482.30, Pneumonia due to Streptococcus, unspecified) that requires IV antibiotics and nasal oxygen.

Sometimes when a patient has a complication, coders are unsure whether to report 99313 or 99302, says Ryan-Niemackl. In defining both codes, the CPT manual notes a "significant complication or a significant new problem" has developed. The differentiating factor is whether that change necessitates the writing of a new medical care plan. Use 99302 when the problem has resulted in a "major permanent change in status" that requires the creation of a new medical care plan. Use 99313 when the change in status is not permanent and a new medical care plan is not necessary.

For example, the pneumonia in the example above, while serious, would not be expected to result in a permanent change in status. However, if the same patient had a stroke, that would likely result in a permanent change in status and require a new medical care plan.

Code Nursing Home Discharges Based on Time

When the patient is discharged from the nursing home, use 99315 (Nursing facility discharge day management; 30 minutes or less) or 99316 (more than 30 minutes), choosing the correct code based on the amount of time required.

Assisted Living Center:Use Domiciliary Codes

Many retirement homes have an assisted living wing as well as a nursing home section. Many elderly also reside in stand-alone assisted living centers.

There is a lot of confusion among coders about how to code physician visits to residents of these assisted living facilities. However, Medicare issued a transmittal on this issue in 2001. Transmittal 1690 (later revised to correct errors in the place-of-service codes in Transmittal 1709) says that the domiciliary, rest home or custodial services CPT codes 99321-99333 should be used to report E/M services provided to residents of a facility that provides "room, board and other personal assistance services, generally on a long-term basis." The transmittal notes that these facilities, which do not have a medical component, are often referred to as "adult living facilities or assisted living facilities." List codes 99321-99323 for new patients and 99331-99333 for established patients.

Coders who report home services codes for E/M services provided in assisted living centers are in error, according to the transmittal. Medicare says that 99341-99350, the home services codes, are for use only when E/M services are provided to a patient in his or her "own private residence and not any type of facility."

Use the Proper Place-of-Service Codes

Another key in coding visits to long-term-care facilities is noting the correct place of service (POS). Putting the wrong number on the claim form can lead to rejection of the claim, notes Richardson.

Code 31 is the POS for a skilled nursing facility (short-term-care or rehab SNF), while 32 is for a nursing facility (long-term care). "The coder needs to determine how the facility designates itself," says Richardson. Code 33 is for assisted living centers.

If the coder is unsure of the facility's designation or unsure which wing the patient resides in, a call to the facility for an answer can save time and avoid claim rejections.