Internal Medicine Coding Alert

You Be the Coder: Billing for DNR Counseling

Question: I recently counseled a Medicare patient regarding a do-not-resuscitate order. The patient resides in a nursing home. She is not short-term, terminal or under hospice care. I spent approximately 30 minutes with her, and no medical problems were discussed. How do I code for this evaluation and management (E/M) service?

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Test your coding knowledge. Determine how you would code this situation before looking at the box below for the answer.

Answer: Because the patient is in a nursing facility, you should use the subsequent nursing facility care codes (99311-99313) to report this service, according to **Tammy Chidester, CPC,** billing supervisor at Upshur Medical Management, a multispecialty practice in Buckhannon, W.Va. The CPT manual states that these codes are used to report the services provided to residents of nursing facilities who do not require a comprehensive assessment, and/or who have not had a major, permanent change of status.

These codes can be used to report counseling and coordination of care. For 99311, an internist would typically spend 15 minutes at the bedside and on the patients facility floor or unit. Code 99312 typically calls for 25 minutes of service at the bedside or on the floor, and 99313 for 35 minutes.

To report an E/M on the basis of time spent counseling and coordinating care, the internist should document in the patient record the time he or she entered and left the room, emphasizes Chidester. Just writing 30 minutes at bedside counseling patient on do-not-resuscitate order is not enough, she notes.

There are two potential problems with trying to get reimbursement from Medicare for this service. The first is billing 99312 for 30 minutes spent counseling when the patient is in stable condition. The CPT definition for 99312 states that usually the patient is responding inadequately to therapy or has developed a minor complication. Code 99311 may be more appropriate because it has been designated as the code to be used for patients who are stable, recovering or improving.

The second problem is that Medicare may not cover the appropriate diagnosis code for this visit. Without documentation of any problems, you are forced to use a V code, such as V65.49 (other persons seeking consultation without complaint or sickness, other counseling not elsewhere classified), Chidester explains. Medicare may deny the claim on the grounds that the diagnosis code indicates that a routine service which is not covered was performed.

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