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Part B Insider (Multispecialty) Coding Alert

CODING: Don't Overbill For Stable Nursing Home Patients

When the doctor drops by the nursing home, it barely seems worthwhile to bill the lowest-paying codes for that crosstown drive. But be careful about billing the big-ticket codes for a flying visit to a patient who's not taking a turn for the worse.

Physician billers should be aware of the benefits and pitfalls of using high-reimbursement codes, for example on the ascending scale from 99311 to 99313 for nursing home services, according to **Jean Ryan-Niemackl**, LPN, CPC, a content analyst in the Quantim Health Information Management division of **QuadraMed**.

Medicare imposes a few factors for those codes, Ryan-Niemacki said in a teleconference on "Successful Coding Strategies for Professional Nursing Home Services." But from her experience in taking part in nursing home chart audits, she reports that Medicare usually looks at "the nature of the presenting problem."

In the CPT Codes book, at the end of the code descriptor for 99311, it states that "usually the patient is stable, recovering or improving." Medicare values that statement very highly, Ryan-Niemacki said. If your documentation says the patient is "'stable, doing well,' obviously that's not going to cut it for documentation," she warned.

If the physician is documenting that a patient's diabetes and hypertension are stable and the patient should continue with the plan of care, that's grounds for a 99311 code, not the higher-paying 99312 code, Ryan-Niemacki said. The carriers also will look for a "problem-focused interval history," meaning the physician's exam is focused on the patient's problem. But the main thing the carriers will look for is an improving patient.

Beware using the 99311 code on a patient more than once in a month, because the carriers will wonder why the physician is seeing the patient so often if the patient is stable or improving.

You can bill a 99312 if the patient responding inadequately to therapy or has developed a minor complication. That isn't too high a threshold to reach, noted Ryan-Niemacki. Frequently, "patients do have things that are going on - small things, or maybe some significant things. Say for instance if the physician is coming in for his monthly visit and the patient has developed a cough or a cold or maybe has a stuffy nose, maybe has some pressure points or starts of a bedsore."

To bill for a 99313 code, the physician should take a detailed interval history, perform a detailed exam and undertake a "moderate to high complexity" amount of medical decision-making. Most importantly, though, the patient should have developed a "significant complication or a significant new problem," Ryan-Niemacki stressed.

For the patient with diabetes and arteriosclerosis, we're not just talking about a pressure point but a significant bedsore. A chronic obstructive pulmonary disease patient should have developed bronchitis or a patient with congestive heart failure should show signs of retaining fluids "in a big way."

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