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Part B Insider (Multispecialty) Coding Alert

COUMADIN CLINICS: Tailor Your 'Flow Sheet' To Specific Patients

Carrier bulletin offers clues on tailoring your documentation

If your practice has a dozen Coumadin patients coming through for Prothrombin Time International Normalized Ratio tests, it may not be able to bill 99211 for each of those patients, say experts. But setting up the correct systems to document the encounters that your nurses are providing anyway can help to justify a 99211 claim in more circumstances.

MedSouth Healthcare in Dyersburg, TN uses a flow sheet that allows the nurse to check the patient's prothrombin time test and other results against acceptable ranges, according to **Dianne Wilkinson**, director of quality assurance. The physician writes the acceptable range for each patient at the top of the flow sheet.

Because MedSouth has the ability to produce the result of the PT test within 30 minutes, the patient can wait for the result. The nurse receives the result and meets with the patient face-to-face to discuss it. He compares the result to the ranges on the flow sheet to see if the patient needs her dosage adjusted.

Because the nurse is making the decision to adjust the patient's dosage, it counts as an E/M service, says Wilkinson. The nurse should include in the "remarks" section a note that spells out what he told the patient to do with her dosage. If the doctor decides to see the patient herself, the form will note that fact, so the nurse doesn't **bill a 99211** separately. The flow sheet is two-sided and printed on bright orange paper so it doesn't get lost in the patient's chart.

Ideally, your flow sheet should document not just that the nurse checked the patient's vitals and talked to the patient, but also that there was a medical necessity for that service, says **Bruce Rappoport** with **RCH Healthcare Advisors** in Fort Lauderdale, FL.

"It really has to be tailored to the patient, not the cookie cutter stuff you would do for every patient," says **Jan Rasmussen** with **Professional Coding Solutions** in Eau Claire, WI.

"If I was going to do a chart review and look at 20 forms, [I'd] make sure that they're not too identical," **Cynthia Swanson**, a cardiology coding consultant with **Seim, Johnson, Sestak and Quist** in Omaha, NE. It should include specific signs and symptoms the nurse checked at the physician's particular order.

Luckily, **Kathleen Brooks**, medical director for Part B Carrier **Wisconsin Physicians Service**, tackled this issue in her "Medical Directors' Corner" column in WPS' February 2003 newsletter. She wrote that the provider should recommend dosage changes based on INR results, plus an understanding of "medication taken, foods eaten, other medication changes," and other issues.

Asking specific questions about food intake, medication compliance and changes to other medications help to show that the nurse is really managing the patient's treatment, says **Joan Gilhooly**, president of **Medical Business Resources** in Evanston, IL. "Simply documenting a vital sign doesn't tell me the nurse was providing an E/M," she adds.

Also, if you're billing for a nurse's visit using 99211, it's important to meet the incident-to billing rules, adds Swanson. Not only must a physician be in the office suite, but the service must be typically a physician service. And a physician also must have ordered the Coumadin testing.

"It's really set up by the physician's order," says **Catherine Brink**, president of **HealthCare Resource Management** in Spring Lake, NJ.

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And in many states, the physician must co-sign the nurse's documentation to show that she reviewed it, adds Swanson. One way or the other, it's important to show that the physician supervised the nurse's evaluation.

Also, if the patient comes back and says he's had "a bad couple of weeks," then that can lead to a physician visit or at least justify a nurse's evaluation, says Brink.

Brooks also noted that Medicare won't pay for telephone services separately.

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