Part B Insider (Multispecialty) Coding Alert

Nursing Facility Visits: This Payer Is Scrutinizing Nursing Facility Visits Carefully

Codes 99309-99310 are under the microscope for NGS Medicare practices.

If you think CMS is only watching your E/M codes when it comes to the office or hospital, think again. One MAC recently reviewed nursing facility care claims data and was stunned at the findings.

NGS Medicare, a Part B payer, announced on May 7 that it had recently reviewed claims for subsequent nursing facility visit codes 99309-99310, and found that its providers in Connecticut, New York and Massachusetts appeared to collect for a higher percentage of these visits than expected.

Based on the outcome of the review, NGS said that it "will be conducting service-specific prepayment reviews of subsequent nursing facility visit codes 99309-99310."

Know these quick facts before you report these nursing facility care codes in the future.

1. Check documentation for comprehensive interval history, comprehensive exam, and/or high-complexity medical decision-making before reporting 99310. CPT requires documentation of at least two of these criteria before you can bill 99310.

For 99309, you'll need to document two of these three requirements: A detailed interval history, detailed exam, and moderate medical decision making.

If your doctor visits a large number of nursing home patients on the same date (which is common), he may not be documenting enough for each patient to meet these high-level codes. Make sure he takes the time after each patient to thoroughly document the record to support the codes he plans to report.

2. If you're coding based on time, be sure to document the pertinent details. Ever since 2008, CPT has published average time spent on the nursing facility codes, allowing you to report them based on time. However, in order for you to bill these visits based on counseling and coordination of care time, the patient must be present during the visit, and you must document the amount of time spent in counseling.

Documentation must include time spent face-to-face (or on the floor/unit) counseling and/or coordinating care, as well as the total time of the encounter. For 99309, the "typical time" cited by CPT is 25 minutes, while you'll need to spend 35 minutes to justify reporting 99310.

NGS's review will be used to identify common billing errors, develop educational efforts and prevent improper payments. If you submit the codes in question, NGS will send you an ADS letter requesting documentation. "Medical records that are not received within the designated timeframe will cause the service and/or claim to be denied," NGS says on its website.

To read more about the review, visit www.ngsmedicare.com.