Eli's Rehab Report

Assisted-Living Evaluations Require Precise Definitions

Physiatrists who evaluate patients in assisted-living facilities should stick to the codes for rest home care services (99321-99333) and should not report the codes for home services (99341-99350) unless they actually provide evaluation and management services in a private residence that is not part of a facility.

Suppose the physiatrist visits a home-bound elderly multiple sclerosis (340) patient. The patient owns her apartment, which is in a retirement village where she receives assisted-living services, such as meals and help with bathing. Do the rest home codes (99321-99333) or the home services series (99341-99350) best describe the physiatrists services?

"CPT reserves the home services codes for evaluation and management services provided in private residences," says **Laureen Jandroep, OTR, CPC, CCS-PCPC-H, CCS,** director and senior instructor for the CRN Institute, an online coding certification training center.

Medicare Eliminates Gray Area

In our example, some coders may argue that because the patient owns her apartment, the unit qualifies as a private residence. Medicare Transmittal 1709, however, eliminates this gray area by stating that you should not report 99341-99350 when a physician provides E/M services to a patient in "any type of facility." Because the patient in the example lives in a facility that provides meals and personal-assistance services, the unit does not qualify as a private residence.

Transmittal 1709 also states that the 99321-99333 series applies to services "referred to as adult living facilities or assisted-living facilities."

Note: If you evaluate a patient in a skilled nursing facility (SNF) or a long-term care facility, you should report the codes for nursing facility services (99301-99316) instead. And if you evaluate a patient in an inpatient rehabilitation unit, you should report the codes for subsequent hospital care (99231-99233).

Patients Condition Affects Code Choice

Physiatrists and coders should read the entire rest home code definitions, because the last sentence of each descriptor provides a useful tip that will help you select the appropriate code. CPT breaks down the new patient rest home care codes (99321-99323) according to whether the presenting problems are of low severity (99321), moderate severity (99322) or high complexity (99323).

If an established rest home patient is "stable, recovering or improving," you should report 99331. "You should not report this code if the physician visits a patient several times within a one-month period," says **Marvel J. Hammer, RN, CPC, CHCO,** owner of MJH Consulting, a healthcare reimbursement consulting firm in Denver. "If I were a payer, I would certainly wonder why a stable patient would require so many subsequent visits."

If you evaluate an established rest home patient who is not recovering or has a minor complication, you should report 99332. Be sure to thoroughly read the physicians documentation, because if the physicians notes state that the patient is doing well or is stable, recovering or improving, your documentation probably does not support using 99332.

If an established rest home patient is "unstable or has developed a significant complication or a significant new problem," you should report 99333.

Medical Necessity Is Key

You should report the home services codes (99341-99350) only when you can document a medical reason for the home visit and why the patient could not come to your office or clinic.

Physiatrists should have no problem establishing the medical reason for the visit, such as arthritis or back pain. But documenting the medical reason that the patient requires home treatment is more difficult. Section 15515 of the Medicare Carriers Manual states that home services patients need not be confined to the home (as is necessary for services under the home health benefit), but the "medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit."

So how do you demonstrate that the patients condition necessitated a home visit? "Your documentation should include a statement as to why a home visit was necessary," such as severe pain, blindness or paraplegia, says **Heidi Stout, CPC, CCS-P,** coding and reimbursement manager at University Orthopaedic Associates in New Brunswick, N.J. Reasons of convenience, such as "the patient couldnt get a ride to my office," will not suffice.

Select Home Services Codes Wisely

Because home services codes do not directly correspond to the office/outpatient E/M codes, you should read each code definition carefully before selecting a code. The level-two established patient home visit code (99348), for example, corresponds more closely to a level-three office visit (99213) than to a level-two (99212).

Remember to assign the appropriate place-of-service (POS) code to your rehab patients. Although 33 is the appropriate POS code for assisted-living centers, you should assign 31 for skilled nursing facilities (short-term-care or rehab SNF), 32 for long-term-care nursing facilities, and 12 for home visits.