

Eli's Rehab Report

Clear Up Coding Confusion for Nursing Facility Assessments for Rehab Patients

Comprehensive nursing facility assessments (99301-99303) can confound even the most expert coder because they don't always follow the same rules that govern other evaluation and management (E/M) codes. Because many physiatrists perform nursing facility assessments for their patients, such as those suffering from strokes (436), multiple sclerosis (340), paraplegia ([ICD-9 344.1](#)) and other conditions, clearing up confusion about these codes is important for proper reimbursement.

Facilities that provide convalescent, rehabilitative or long-term care must perform assessments of the patient's condition when he or she is admitted to the facility and annually thereafter. Assessments also must be performed whenever the patient's status undergoes a major permanent change.

Assessments Affect Total Reimbursement Outlook

There are a number of issues that make these codes unusual, says **Mary Falbo, MBA, CPC**, president of Millennium Healthcare Consulting Inc., a national healthcare consulting firm based in Lansdale, Pa., that specializes in financial and healthcare management with a focus on physician compliance, coding, billing and reimbursement.

Coders must be alert to these key differences to assign the assessment codes correctly. This is especially important given the high relative value units (RVUs) assigned to these codes. Correct coding can make a significant difference in the level of reimbursement received.

Even more important than the reimbursement for the assessments RVUs, these codes affect a patient's total care allowance for the year, says **Laureen Jandroep, OTR, CPC, CCS-P**, owner of A+ Medical Management and Education, a coding and reimbursement consulting firm and a national CPC training curriculum site in Egg Harbor City, N.J. Jandroep has participated in nursing facility assessments as a practicing occupational therapist and played a role in determining patients care plans following assessments. With the prospective payment system (PPS) entering the long-term care arena, the nursing facility assessment really affects reimbursement. The assessment determines what needs the patient has and how sick he or she actually is. During the assessment, the physician determines whether the patient requires additional assistance or care, and those factors go into the calculation of the patient's minimum data set (MDS) rate, which in turn determines the prospective reimbursement.

The Basics of Nursing Facility Assessments

Nursing facility assessment codes are complex evaluations because they cover the entire scope of the patient's care, not just the factors that make up the typical sick visit E/M codes, says Jandroep. The assessment looks at the patient's nutritional and psychosocial status, his or her functional status and impairments, and the rest of the patient's total medical profile. Use these four key factors in determining how to code nursing facility assessments:

1. Assign 99301, 99302 and 99303 for services provided to both new and established patients. There is no distinction between new and established patients with these codes, Falbo notes. This is something that often trips up coders. They want to apply the same rules they use with consultations or outpatient visits one series of codes for new patients and another for established. This rule of thumb doesn't apply with nursing facility assessments.

2. Comprehensive assessment codes encompass specific and detailed components. Whenever assigning 99301, 99302 or 99303, the chart must include the completion of a resident assessment instrument (RAI), Falbo says. An

RAI is a comprehensive, standardized tool that allows the family physician to measure each residents functional capacity. The RAI will include an MDS that typically contains the patients medical conditions, history and status; mental and physical functional status; sensory and physical impairment; nutritional status; mental and psychosocial status; cognitive status; special treatments and protocols; discharge, activities and rehab potential; and drug therapy, among other components.

The physiatrist would work with the patients other caregivers, such as dietitians, physical, occupational and speech therapists, and psychologists to create a full picture of the patients condition so his or her plan of care can be written for the following year.

3. Coders can assign these codes more than one time during a patients stay in the nursing facility. To ensure quality care of patients in long-term nursing facilities, it is vital for the physician to periodically evaluate the many factors that will have an impact on their well-being, says Falbo. Most states, which are charged with licensing nursing facilities, require these comprehensive assessments at least once a year (99301). In addition, a comprehensive assessment would be conducted, reported and billed if the patient experienced a significant change in status (99302). If a patient is readmitted (e.g., for hospitalization for a hip fracture), a new comprehensive assessment would be warranted (99303).

4. Comprehensive assessments include services related to the patients care that may have occurred at other sites on the same date. Occasionally, a physiatrist will have seen a patient in another setting and decide to admit or readmit the patient to a nursing facility. The patient may have been in the hospital or seen in the office or emergency department, says Falbo. All of the E/M services provided in these other situations on the same date of service would be included in the comprehensive assessment code and would contribute to the level of service reported.

The medical record for the assessment should refer to the previous E/M services, she says. For example, the physician may note, Please refer to the review of systems and medical history dictated earlier today, and confirm the date these services were performed.

On the other hand, hospital discharge or observation discharge services performed on the same date as the nursing facility assessment may be reported separately. The place of service would be different, and therefore, they probably have separate HCFA reporting criteria (the nursing home would be under the PPS, and the hospital would report an inpatient E/M service). If the Medicare carrier is the same for both, the coder should append modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the nursing facility assessment code to be safe. But coders should check with their individual carriers to determine specific reporting requirements.

Determining the Level of Service to Assign

Because of the nature of care provided by nursing facilities, residents undoubtedly will have serious health conditions. This creates a challenge for physicians and coders to determine which level of service to bill when comprehensive assessments are conducted.

Jandroep offers the following examples to illustrate how each level of assessment should be coded.

Example 1: Code 99301. This is for the annual assessment requirement, says Jandroep, when the patient must be assessed on all levels to determine whether the plan of care needs to be changed and to provide a comparison to the previous years status.

For example, a 52-year-old female patient suffering from multiple sclerosis has been a resident of a nursing facility for three years. During the previous year, the patients physiatrist has seen her periodically for sick visits (99311-99313) and routine preventive care (99396), and to oversee the patients therapy plan. At the end of the year, the physiatrist conducts an annual comprehensive assessment using the RAI and MDS. Services typically would be assigned the lowest code level, 99301.

Example 2: Code 99302. This code is used when the patient has developed a significant complication or new problem, and his or her status has permanently changed, says Jandroep. For instance, if a patient only needed a minimal amount of assistance to ambulate during the last assessment, but halfway through the year, his or her condition worsened, requiring moderate to maximum assistance, the psychiatrist might say, We need a complete assessment of this patient again, even though her annual assessment wont be performed for another three months.

For example, a 66-year-old male quadriplegic ([ICD-9 344.00](#)) patient has a transient ischemic attack (TIA 435.9) and exhibits a significant change in mental status. These events trigger a new MDS, and the conditions involve medical decision-making of moderate complexity. Services typically would be assigned the level-two code, 99302.

Example 3: Code 99303. The 99303 is used for initial admission assessments or for readmission, says Jandroep. It is generally the most comprehensive because the patient normally hasnt been seen before or hasnt been seen with the same problems he or she would be having on admission or readmission.

For example, a 70-year-old female resident has had two cerebrovascular accidents (CVAs or strokes) requiring hospitalization. Because of the severity of the patients condition and the complexity of the medical decision-making on readmission, the comprehensive assessment typically would be coded as 99303.

Not the Same as Subsequent Nursing Facility Care

Codes 99311-99313 are reported for subsequent nursing facility care. These also apply to both new and established patients and are assigned for physician visits that include a review of the medical record, notation of changes in the patients status, and reviewing or signing orders. They usually are related to an isolated illness like a persistent cough, pain, loss of weight, etc. Therefore, these codes should not be confused with the more comprehensive and higher RVU assessment code (99302).

And remember, whether youre coding for standard E/M services or nursing facility assessments, documenting the appropriate history, exam and medical decision-making for each level of service is important, whether your practice or health system adheres to the 1995 or 1997 documentation guidelines.