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# Long-Term Care Survey Alert

## Quality of Care: Boosting Physician Coding Know-How Pays Off for Residents and SNFs

**Are your facility's attendings underbilling in these key scenarios?**

Looking for new ways to improve resident outcomes, reduce hospitalization -- and get more physician coverage, to boot?

Key: Make sure attending physicians understand how to get paid appropriately for services provided in the nursing facility.

The reality: SNF patients come from hospitals and most are fairly sick with lots of clinical problems, observes **Charles Crecelius, MD, PhD, CMD,** a nursing home medical director and health policy advisor for the American Medical Directors Association. And if you treat the patients aggressively, they will return to a lower level of care more quickly, which is cost effective and part of practicing "valuebased medicine," he adds.

Using that approach, physicians earn more money by "doing the job right, improving care -- and also saving society money," says Crecelius. "It's a win-win situation."

**Review Evaluation and Management Coding**

Billing the appropriate level of evaluation and management visit probably ranks as the biggest misunderstanding among physicians seeing nursing home patients, says Crecelius. "You really need to know the elements necessary to bill each level and understand the role of time in determining the right level."

The various codes have time elements that the physician can use as guidelines, says **Dennis Stone, MD, CMD, MBA,** chief medical officer for Signature Healthcare in Louisville, Ky.

**Focus on Complex Regulatory Visits**

Physicians tend to underbill for complex regulatory visits, says Crecelius. Why? They incorrectly believe they can't bill a higher code if the patient isn't "decompensated or really ill on the day of the visit." Yet the patient may have a lot of complex medical problems requiring monitoring and planning, he points out.

Example: Suppose the resident has diabetes, dementia, high cholesterol, hypertension, and depression, Crecelius says. If the physician has "an active thought process going on in all those areas in considering what needs to be done," that may result in a higher level visit, which could often be a 99309 (level 3 subsequent nursing facility care).

"The key is complexity of medical decision making," Dr. Crecelius stresses.

Note: CPT code 99309 would require decision making of moderate complexity, and physicians would typically spend 25 minutes at the patient's bedside and on the facility's unit or floor. (To look up nursing home visit CPT codes, go to https://www.aapc.com/codes/ and sign up for a free trial.)

**Take Credit for Follow-up**

If the resident/patient developed a new problem since the physician's last visit, the physician can bundle that problem into the next visit -- "if he or she did something about it, including via phone orders," says Crecelius.

Example: Suppose a resident developed a UTI, and the physician ordered treatment. Then at the next visit, the physician decided to get a follow-up urinalysis and look into why the resident developed a UTI, Dr. Crecelius says. The physician

could include that problem in his billing -- if the physician is "dealing with the problem in a proactive fashion. I wouldn't count a one-time order of Tylenol for a headache, but few problems in long-term care are that simple."

Physicians can't bill for handling resident's clinical problems by telephone. "But if you keep accurate records of what problems occurred since the last visit, you can bill a higher level by addressing/following up on those problems at the next visit," Crecelius counsels.

Smart move: Crecelius knows of one physician with a system that captures all of the faxes a facility's nurses send him about residents. The system allows him to "show up on the next visit with every communication he's had since the last visit."

**Consider Using a Checklist**

Physicians who don't know how to document to support the level of E/M code tend to underbill, in Crecelius' experience. "There are various forms and templates" to help physicians with documentation, he says. For example, AMDA provides tools to help physicians in that regard.

"You don't have to use computer-generated notes," Dr. Crecelius says. And "if you do -- and can't tell the difference in the notes from visit to visit -- that can be a problem. You have to make sure to change things that need to be changed."

The physician can, however, use a checklist to ensure he asks the right questions and takes credit for the work he does, Crecelius adds. For example, he finds that physicians tend not to look at skin problems like they should.

**Build Up a Patient Load**

When physicians have low numbers of patients in a nursing facility, they almost have to see all of them in a single day to make coming to the facility cost-effective, Crecelius observes. "If you have five to six people in a facility, you can't afford to go there several times a month."

Thus, "it behooves doctors to build up appropriate numbers of patients in a nursing facility so they can be there more often," Crecelius urges. Ideally, the physician should be in the facility once a week, he says. That way, the physician "can deal with problems without all of those phone calls from the facility in between visits." There's no reason physicians can't build up a sufficient number of patients in urban and suburban nursing facilities, in Crecelius' view. "In my best facility, I have 120 patients and am there two to four times a week. That way, I can nip things in the bud and keep patients out of the hospital much more efficiently." By being there more often, he can "treat small strokes, blood clots, and pneumonia in the facility."