Internal Medicine Coding Alert

CPT: You CAN Go Home Again (to the Patient's Home,That Is) and Get Paid

House calls may not be as common as they were a century ago, but Medicare and many private carriers will pay for physicians to see patients at home if and it's a big "if" they document a medically necessary reason that the patients can't come to the office.

Reimbursement is higher for the home services codes than for the office/outpatient E/M codes. For example, home services code 99348 pays $73.84 while a comparable office visit code, 99213, pays $50.31 nationally, not adjusted for region. However, many physicians who would like to see certain patients at home don't use these codes because of confusion about how to use them properly, how often they can be billed and who can use them.

Home Visit Codes:How,Where and When to Use Them

Use a code from the 99341-99345 series for home services provided to a new patient and a code from the 99347-99350 series for a home visit to an established patient. The higher numbers in each category reflect greater complexity.

Use these codes only for visits to a patient's private residence. Be sure to use the correct place of service (POS) code for a home visit: 12.

Some offices try to bill visits to assisted living center residents using these codes, but you should bill visits to those patients using the domiciliary/rest home codes (99321-99333).

Medical Necessity Is Key to Reimbursement

Use the home visit codes only when you can document a medical reason for the visit and a medical reason that the patient cannot make the trip to the office or clinic.

The medical reason for the visit is easy to document. It can be any type of problem that the physician would see a patient for in the office, such as influenza or a regular check for high blood pressure.

Documenting the medical reason that the patient needs treatment at home is more difficult. Section 15515 of the Medicare Carriers Manual says the home services codes can be used when a physician provides E/M services to a patient in a private residence. The patient does not have to be confined to the home (as is necessary for services provided 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," the MCM says.

So how can you show that it was medically necessary for the patient to be seen at home?

"There is no national policy on what 'medical necessity' is," says **Jan Rasmussen, CPC**, president of the Eau Claire, Wis.-based Professional Coding Solutions and a former member of the AAPC advisory board.

That leaves it up to physicians to interpret when a payer may consider it medically necessary for them to see a patient at home.

The key is to document a medical reason that the patient can't travel, says **Karen Jeghers, PA-C, CPC,** president of Compliant Billing Services in Carver, Mass.

"The patient may be blind, or a paraplegic or in severe pain and unable to travel to the office without assistance,"

Jeghers says. "The reason cannot be convenience for example, that the patient can't get transportation."

Although Medicare doesn't require "homebound" status, most patients requesting home services probably meet the definition of homebound, Rasmussen says. To be considered homebound, the patient does not have to be bedridden but must have an illness or injury that makes it difficult to leave the home without supportive devices or another person's help. See Section 2051.1 of the MCM for further detail on Medicare's definition of a "homebound" patient, http://www.hcfa.gov/pubforms/14_car/3b2051.htm#_1_2. Examples of "homebound patients" given there include patients with arteriosclerosis so severe that they must avoid all stress and physical activity, and patients who are blind or senile and require another person's assistance to leave home.

Bill the home services codes as often as a visit is medically necessary, just as you would in the office, Rasmussen says.

"Medicare is going to pay them as often as they would any office visit, providing that you have documented medical necessity," Rasmussen says. "The condition itself should drive the frequency, not the fact that the patient is at home."

Choosing the Correct Code

Be sure to read the required components before selecting a code. Home services codes don't correspond directly to the office/outpatient E/M codes, and that confuses physicians sometimes, Jeghers says. "They tend to think in terms of a level 1, 2, 3, 4," she says.

However, the level-2 home visit code for established patients (99348) corresponds more closely to a level-3 office visit (99213) than to a level-2 (99212). For example, CPT says 99348 is typically for a problem of low to moderate severity, includes 25 minutes of face-to-face time with patient or family, and requires two of these three components: an expanded problem-focused interval history, an expanded problem-focused examination, and medical decision-making of low complexity.

If the doctor performs a procedure (such as a nebulizer treatment) during a home visit, be sure to code that in addition to the home services code, Jeghers says.

Some Office Staff Can Make House Calls

Physician assistants and nurse practitioners can use the home services codes as long as they bill under their own provider numbers.

However, in most situations, a nurse or medical assistant cannot bill the codes "incident-to" the physician because incident-to rules require the physician to provide "direct supervision" and be on-site when services are provided.

Let's say a nurse visits a patient's home to check blood pressure and assess the patient's response to a new medication, then calls the office for instructions from the doctor. The nurse cannot bill incident-to the physician because the doctor is not on-site to provide direct supervision. However, the office may be able to factor the time spent at this nurse visit into the next physician visit, Jeghers says.

There is an exception to the incident-to rule, though, that will allow office nurses to provide services to some "homebound" patients. In some medically underserved areas, where only a few physicians serve a broad geographic area and often there is no home health service, Medicare permits nurses and other "paramedical personnel" to provide services to homebound patients incident-to the physician under "general" rather than "direct" supervision, Rasmussen says.

This exception is spelled out in Section 2051 of the MCM, http://cms.hhs.gov/manuals/14_car/3b2051.asp#_1_1. This provision will apply only in very isolated areas, Rasmussen notes. In these cases, you code the services of the nurse or paramedical personnel using the home services codes incident-to the physician.

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