Part B Insider (Multispecialty) Coding Alert

COVERAGE: Dx Should Be Reason for Extra Nursing Home Visits

If a physician visits a nursing home patient more frequently than Medicare will usually cover, it's up to the physician to explain in the electronic record what happened, according to **Cahaba GBA's** draft policy.

"When it is medically necessary to visit a nursing home patient at a frequency greater than usual, list as the primary diagnosis on the claim the symptom or sign that made it necessary for the physician to see the patient," Cahaba instructs physicians. That way, you won't have to submit medical-necessity documentation later.

Cahaba gives the example of an 80-year-old nursing home patient with hypertension and mild dementia, seen on Jan. 10 for a routine follow-up visit. The patient is doing well, but on Jan. 20 the patient complains of shortness of breath, so the physician returns to the nursing home.

The Jan. 10 claim should list dementia and hypertension as diagnoses, but the claim for Jan. 20 should list "shortness of breath" (**786.05**) as the primary diagnosis, Cahaba says. That will let Cahaba know why it was necessary for the physician to return so soon. If the shortness of breath was due to congestive heart failure and the physician must recheck the patient on following days, the subsequent visits should use CHF as the primary diagnosis, but the claim may list other diagnoses.

Cahaba also clarifies that instead of billing an evaluation and management code for a decubitus ulcer, physicians can bill CPT codes 97601 or 97602 (active wound care management) if they meet all of those codes' requirements. Because there's no "incident-to" arrangement in nursing homes, nonphysician practitioners may never bill under the physician's Medicare number unless the physician is present during the entire encounter.

Cahaba also clarifies that if a physician just happens to be in the nursing home visiting a patient and stops in to check on another patient's minor problem, such as chapped lips, that doesn't count as a billable E&M service.

Recent hospitalizations, onset of chest pain, respiratory difficulty, new neurological deficits, abrupt onset of severe pain, fever, abnormal bleeding, new urinary incontinence or recurrent falls all may be reasons to bill for more frequent visits, says Cahaba in the policy, which is open to comment until April 15.