CPT Codes: The Evolution and Current State of Codes and Their Use

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The nuances of Current Procedural Terminology (CPT) coding and documentation have always been a challenge for long-term care (LTC) physicians, particularly now that the continuum of care has expanded to include subacute, domiciliary/custodial settings, assisted living, and housecall care. The complexity and nebulous interpretations of these codes have cost physicians huge sums of money and actually driven many excellent, caring physicians to stop providing services to our nation’s frail older residents. The American Medical Directors Association (AMDA) has long worked diligently with the Centers for Medicare and Medicaid Services (CMS, formerly HCFA, the Health Care Financing Administration) to stem and hopefully reverse this trend. At the same time, AMDA has provided many informational updates to its members to help them understand the codes and how to apply them accurately. Unfortunately, it is an enduring challenge as the rules and interpretations change virtually every year. As we read frequently in the press, physicians across the entire care continuum are so disenchanted with the system that many are opting not only out of HMO-Medicare contracts but out of the Medicare program entirely. This adds greatly to our challenge as medical directors to attract quality physicians to attend to our LTC patients. This article will endeavor to identify some of the many missed opportunities physicians overlook to be paid fairly and appropriately for the work they do in long-term care.

First, a brief review of the impact AMDA has already had on the CPT codes.

CONCERNS RAISED, STRATEGY DEVELOPED

AMDA used the profound and widespread implications of the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) to get the attention of CMS’s Division of Institutional and Post Acute Care. This law was an outgrowth of vigorous consumer advocacy for more physician presence and improved quality of care in our nursing facilities. What followed was an extremely fruitful period of cooperation between CMS and AMDA. AMDA developed new CPT codes designed specifically to reflect the significant physician work mandated by the regulations stemming from OBRA ’87. These suggestions were condensed and published in the Federal Register in November 1991, with some rewording to conform to the CPT format. AMDA also was privileged to develop the vignettes for these codes and have them adopted by the American Medical Association (AMA) in their CPT manual.

Following the codes’ establishment, the next step was to assign new Relative Work Values (RVUs) for each of the codes. These RVUs are the multipliers used by the AMA to establish the amount of work required for each coded service. The original values assigned by CMS were based on assumptions reflecting no clear understanding of LTC and the work it involved. The president of AMDA at the time, Roman M. Hendrickson, MD, CMD, wrote a letter to CMS identifying four major problems with the proposed code values:

- The work a physician was expected to do upon admitting a patient to a nursing facility was profoundly undervalued
- All of the proposed code reimbursement values were based on historic costs that were undervalued because of the practice of multipatient visit down-coding—a carrier “ploy” that stated the work done for every LTC patient after the first was only worth half the value of the initial patient.
- The concurrent, Congressionally mandated, 15% limit on payment increase formulations used by CMS to adjust physician reimbursement caused the new LTC reimbursement code values to be lower then they were before the adjustment!
- CMS was using grossly inaccurate encounter times upon which the physician work values were based.

CMS responded to AMDA’s concerns and included “nursing home practices” as one of the special areas to be reviewed by panels of carrier medical directors. This was a major coup, because it circumvented going through the AMA’s Relative Value Update Committee (RUC) process, which has rarely supported AMDA’s interests.

CODES APPROVED, LONG-TERM CARE WORK ACKNOWLEDGED

This maneuver did not just happen. In 1992, AMDA leaders scheduled a series of meetings with key congressional staff stressing that Congress specifically instructed CMS in
OBRA ’87 to adjust payment to nursing facilities under Medicare to reflect the new costs required to comply with nursing home reform. Partially as a result of this awareness campaign, Senator David Pryor, chair of the Senate Special Committee on Aging, wrote to CMS in October 1992:

“I have been made aware that [with] the promulgation of the physician fee schedule implementing physician payment reform, payments to physicians who care for nursing home residents have been assigned some of the lowest values of all physician visits. Since increased physician involvement in the clinical aspects of nursing home care is one of the cornerstones of nursing home reform, I am deeply concerned that the level of payments for nursing home visits may undermine the intent of OBRA 1987. I am also concerned that it may threaten resident care by exacerbating the historical problems faced by nursing homes in attracting and retaining competent physicians and medical directors to care for the residents and to manage that care.”

When the Revised Medicare Physician Fee Schedule was published in November 1992, it revealed that AMDA’s work had paid off with significant gains for LTC physicians. It established the present nursing facility codes and was able to get the carrier medical directors to agree that the reimbursement rate should be at near parity with hospital visit reimbursement. Since that event, it has been up us as LTC physicians to validate that parity/value and to justify any further increases in reimbursement. With that success, however, there was an implied expectation that the work provided would, indeed, justify that parity.

The guiding principle for LTC assessment codes was—and remains—the Minimum Data Set (MDS) requirements. It is only appropriate to encourage and pay physicians to assist in the work expected to complete an instrument that requires documentation of the patient’s:

- diagnoses
- health conditions
- oral/nutritional/dental status
- medications
- treatments
- routines
- preferences
- cognitive patterns
- communication
- hearing acuity
- mood behavior
- physical functioning
- continence
- discharge potential

or the associated 78 Resident Assessment Protocols (RAPs) triggered by that assessment including:

- delirium
- dementia
- visual function
- communication
- ADL function
- rehab. Potential
- incontinence/cath needs
- psychosocial well-being
- moods/behavioral problems
- activities
- falls
- nutritional status
- feeding tubes
- fluid maintenance
- dental care
- pressure ulcers
- psychotropic drug use
- physical restraints

Over the years, there has been some argument and misunderstanding about how the Assessment Codes are to be used when a physician provides this service. The latest interpretations (2001 and counting) are:

- 99303 for an initial admission MDS visit or a readmission MDS visit of a patient returning from the hospital with problems of moderate to high medical complexity requiring a comprehensive history and physical examination.
- 99302 for a readmission MDS visit of a patient returning from the hospital with problems requiring only an interval update (no “new chart”) and involving moderate to high medical decision making or a visit associated with the assessment of a significant change in condition requiring a new MDS.
- 99301 as part of the annual MDS update requiring a detailed, interval history, a comprehensive physical but only low medical decision complexity.

Initially, the 99303 was to be used for all nursing facility (NF) admissions with the intention that the physician would do a comprehensive assessment. Unfortunately, over the years, CMS saw “See Hospital H&P” too often and readjusted the definition to more closely reflect the work actually being done. It is understandable that CMS is using its reimbursement leverage to get the physician’s attention because it the agency has been charged with using that MDS and RAP data to measure quality and health care policy issues.

Another area of evolving interpretations has been the difference between OBRA’s required “initial” physician visit and earlier visits sometimes required because of medical acuity.

The term initial MDS visit may not be the same as a first visit to a nursing facility patient. There will be times when the physician or a nurse practitioner or physician assistant may see the patient for an acute problem requiring prompt attention before the physician is prepared to address the MDS admission assessment visit because of the lack of complete medical records, pending lab results and therapy assessments, or time constraints. The “required” visit must be within the first 30 days of stay, but many other health problems may need addressing before the physician is able to complete the required comprehensive assessment.

AMDA also was instrumental in addressing CMS’s need for viable data from the required nursing facility discharge summary by actually getting them to pay for the work involved in
DETERMINATION OF MEDICAL NECESSITY

Key points LTC physicians need to know include:

- Documentation has almost become an art form. Among the codes, to get it consistently right and provide the required information for reimbursement, physicians may be penalized for unintentionally misusing or misapplying the codes. To get it consistently right and provide the required documentation has almost become an art form. Among the codes, physicians may be penalized for unintentionally misusing or misapplying the codes.

OTHER CLARIFICATIONS

Over the years, more than one LTC physician has been penalized for unintentionally misusing or misapplying the codes. To get it consistently right and provide the required documentation has almost become an art form. Among the key points LTC physicians need to know include:

DETERMINATION OF MEDICAL NECESSITY

Nursing facility patients may be seen more than once a month. CMS’s own Program Memorandum4 states as policy: “...all other medically necessary visits are covered under Medicare Part B. Keep in mind that many patients now admitted to SNFs and NFs have acute and chronic conditions of sufficient intensity to require frequent physician visits (eg, once a week or once a day).

Over the years, the carriers have floated occasional screens implying only 1.5 visits per month would be allowed. This was in response to the occasional abuse by errant physicians who were performing visits that were not medically necessary. AMDA took the high road on this issue, however, and insisted that the attending physician’s decision and documentation that a visit is medically necessary should be held paramount in the LTC setting. In a White Paper in October 1999, entitled “White Paper on the Determination of Medical Necessity in Long-term Care Facilities,” AMDA took the stand that:

“Evaluation and management services, diagnostic tests and procedures, treatments, medical/surgical procedures, equipment or supplies that in the judgment of the attending physician—(or NP or PA when permitted by federal and state statute)—are required to professionally assess, plan, manage, and monitor the health care of a resident or patient in the facility within the parameters of generally accepted principles of medical practice.”

It is vital, however, that the physician document the rationale for the additional visit that delineates clearly why the physician made the visit and what specific services were provided and why. Each of the following is a lead-in phrase that may be used to validate the visit:

- Patient reports...
- Nursing notes...
- Attending physician requests...
- Lab data indicates an abnormality that requires a face-to-face examination...
- Family member requests evaluation of...

- Regulatory requirement to assess the following health problems...
- Previous medical problem requires follow-up for...

The physician must be prepared to justify that the service or intervention is sound clinical practice, and that it reflects reasonable and realistic goals and expected outcomes. Referring to definitions of medical complexity in the CPT code book is also key to determining which level of care will apply.

Note: It may be difficult for Medicare carriers to recognize which visit is a regulatory visit and which is a visit for care of an acute problem. The diagnosis listed is one way to identify the purpose of the visit. If the acute problem is an exacerbation or follow-up of a chronic medical condition, the diagnosis will be the same, however. When this is the case, it is essential to attach copies of the progress notes for the scheduled and acute care visits to the claim for the carriers. This will enable them to distinguish between services.

SUB-ACUTE VISITS

The term sub-acute actually has no bearing on reimbursement for physician services. A medically necessary visit is a medically necessary visit. Certainly, when a patient returns from hospitalization (sub-acute), he or she is in a more unstable condition and will require more physician attention, but each and every visit must be justified. The documented rationale for the visit must stand on its own.

ASSUMING CARE

When assuming care for another physician’s patient and no new MDS is required, code 99313 best reflects the services because, although no new MDS is necessary, there are extensive problems, systems, and findings that must be reviewed and addressed, and confirming or instituting a new medical plan of care requires higher levels of medical decision complexity.

PROLONGED CARE SERVICES

In July of 1993, CMS approved the use of the prolonged visit codes for extended inpatient clinical services. The addition of these codes (99356 and 99357) recognizes that there are times that extended visits are required because of patient acuity. Parameters that must be met to bill for this code include: (1) one of the nursing facility visit evaluation and management (E&M) codes (obviously a 99313) submitted for that period of service, (2) the time required to provide the prolonged service was at least 30 minutes longer than the customary time required to do a 99313, (3) the service must be face-to-face contact—not floor time—but does not necessarily have to be continuous and (4) the medical record documents the duration and reason for the prolonged service. Time for such activities as family conferences obviously is not countable. It should be noted that CMS expects these parameters to be met in no more than 1 in every 10,000 visits.
HOSPITAL DISCHARGE OR OBSERVATIONS SERVICES

Hospital stay discharge services performed on the same date as a nursing facility admission or readmission may be reported and billed separately using coded 99238 or 99239, as appropriate. For a patient who has only been hospitalized briefly for observation status on the same date as the nursing facility admission or readmission, the code 99217 should be used. For a patient admitted and discharged from observation or inpatient status on the same date, codes 99234–99236 are appropriate. The patient must be in observation for a minimum of eight hours. If the patient is in observation status for less time, report services from initial observations using 99218–99220. Remember that for a concurrent Nursing Facility Code to also be billed, the patient must require a new MDS to be generated. No MDS = No Assessment Visit Code.

ASSISTED LIVING

The definition for this level of care is in presently in a state of flux as is the profile of the residents/patients who are in such facilities. It is very unclear if these facilities should be considered domiciliary care or house calls. For the purposes of CPT coding, an assisted living facility provides room, board, and other personal assistance services without a medical component. CMS is stating that the domiciliary codes, 99321–99333, should be used for this site of service. The question is, however, if a resident is living in a congregate living situation is it the person’s residence or is he or she receiving residential care? Some carriers are accepting that these facilities are the patient’s residence, and others are insisting that they are care facilities. At present, there is no definitive answer. However, CMS indicates that CPT codes 99321–99333 should be used for patients living in resident care settings, not in private residencies.

RURAL CARE

Billing in rural areas has created questions for many providers who are unsure what a rural area is or whether or not they are practicing in one. According to CMS, “an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area. . . .”5 A physician practicing in a rural area is entitled to a larger reimbursement, but only if his or her practice is actually located in the area designated as a “Medicare Shortage Area.” They are then able to add the modifier “QB” to the visit code. There is a 10% bonus for all such visits.

INTERDISCIPLINARY TEAM ROUNDS

Although physicians—especially those who also are medical directors—spend much time in interdisciplinary team rounds, there are no reimbursable CPT codes for these activities. The attending physician, however, should document as previst work, the time and activity required by the conference as part of the justification of medical decision-making complexity.

MID-LEVEL PRACTITIONERS

With the growing acuity of nursing home patients, the use of mid-level practitioners—nurse practitioners (NPs) or physician assistants (PAs)—is a widely accepted practice. Physicians must use a modifier on each code in their billing to indicate when a practitioner performed the service. The two most common modifiers are “AL” for nurse practitioners and “AN” for physician assistants. Each physician should check the laws is his or her state, as well as the rules of the facility, before using NPs or PAs. Do not use “incident to” for NP/PA services in a nursing facility—that parameter cannot be used for that site of service.

OBRA regulations clearly state that the physician must see the patient every 30 days after the admission MDS visit for the first 90 days and then, depending on complexity, every 30–60 days thereafter. In some states, however, the carriers allow the PA or NP to provide every other regulatory visit even during the initial 90 days, and in some cases, they also allow authorization for therapies and recertifications. Policy varies across the country. The admission order and initial plan of care, however, are still exclusively the purview of the physician.

HOSPICE PATIENTS

Medicare law does not provide for physician services associated with the hospice diagnosis to be reimbursed separately from the funding it provides the hospice program. This does not preclude, however, the NF attending physician from billing Medicare Part B for medically necessary services provided to a hospice beneficiary. The only stipulation is that the services are for some other condition than the diagnosis which made the patient Hospice eligible.

TIME

Something CMS has managed to avoid for many years is the value of time. Unlike the office or hospital-based physician who spends most of the day at one or two sites of services, somewhat like any factory worker who is expected to show up for work, work, and then go home, LTC physicians, must go to multiple sites of service to provide the required care. This requires time, and as such, practice expense to the LTC physician. This reality has been systematically ignored by CMS with no logical basis other than it is not an identifiable expense that can either be allocated to direct or indirect practice expense. If the additional time required to go to the NF or the patient’s home is added to the cost of providing that care, the present reimbursement for that service does not make economic sense—another reality CMS would prefer to ignore. AMDA is working with the American Association of Home Care Physicians to correct this injustice and the denial of access to care this policy represents.

Hundreds of thousands, if not millions, of dollars have been lost to LTC physicians because of lack of understanding of some of the nuances discussed above. In a time when the press focuses on the occasional episode of a physician abusing the system, it should be pointing out that the system is riddled with the arcane ways that health care policy can abuse the
physician. Only through the continued, diligent work by AMDA and its members can we hope to find our way through this morass and continue to attract quality physicians to long-term care.

REFERENCES
4. HCFA Program Memorandum, 8/93, Trans #b-93-3.
5. Carriers Program Memorandum, 3/00, Trans #B–00–11.

MEDICAL NECESSITY AND DOCUMENTATION ISSUES

Physicians may visit patients in nursing facilities and other LTC settings as frequently as is medically necessary. Medicare acknowledges that the acuity of nursing facility patients is higher than ever and that these patients require more of the physician’s time. However, there is no definitive or widely accepted definition of “medical necessity.”

AMDA believes that the attending physician’s decision and documentation should be held paramount in the LTC setting. In October 1999, the association released a white paper that included a working definition of “medical necessity” as follows:

“Evaluation and management services, diagnostic tests and procedures, treatments, medical/surgical procedures, equipment or supplies that in the judgment of the attending physician—(or NP or PA when permitted by federal and state statute)—are required to professionally assess, plan, manage, and monitor the health care of a resident or patient in the facility within the parameters of generally accepted principles of medical practice.”

The physician must be prepared to justify that the service or intervention is sound clinical practice and that it reflects reasonable and realistic goals and expected outcomes. The physician also must be willing to address and defend a rationale in relation to premorbid function, excess disability, and the expected positive outcomes of any prescribed intervention. However, explanations of the above need not be explicitly documented in detail prospectively in the clinical record.

In 1995, AMDA released a Position Paper on Appropriate and Necessary Services, which states that the organization “strongly supports the physician’s role in the prescribing of rehabilitation therapies, durable medical equipment, transportation, psychological services, respiratory treatments, and any other ancillary services that require physician concurrence. Proper prescribing is the result of physician education, judgment, and experience.”

It is important to note, however, that in order to be reimbursed, services must be covered by statute. For example, until recently, most immunizations and screening tests were not covered, regardless of any definition of medical necessity, but now, pneumococcal and flu vaccine were now covered by law.

Documentation Requirements

With the current atmosphere and emphasis on fraud and abuse, physicians need to make patient visits as they are needed and fully support these visits with appropriate documentation. The following suggestions can help practitioners ensure that their documentation accurately reflects their work and enables them to apply the appropriate codes to their services:

- Chart promptly and include all necessary details.
- Never white-out, erase, or write over errors. Instead, draw a line through the error so that deleted information remains legible; then write “error” or “mistake in entry.”
- Never insert words into an already completed entry. This may be interpreted as an attempt to alter the record.
- If there is no entry for a specific area or space, write “NA” or draw a dash in the space to show that it was not overlooked.
- Write all entries legibly and in ink.
- Keep sequence chronological.
- Avoid vague statements (eg, “turned at intervals,” “checked periodically”).
- Only use abbreviations approved in the facility’s policy manual. A full signature should be included on any form where any information is initialed.
- Follow any specific policy and procedures your facility has for completing resident charts.
- Never, ever, ever sign blank forms!!!!