GUIDE TO POST-ACUTE AND LONG-TERM CARE CODING, REIMBURSEMENT, AND DOCUMENTATION

amda
The Society For Post-Acute And Long-Term Care Medicine™

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INTRODUCTION

Coding and documentation have presented challenges for post-acute and long- term care physicians over the years, particularly as the continuum of care has expanded to include assisted living, subacute, and home care settings. This guide is designed to enable you to code appropriately for your visits to patients in these varied settings. Detailed vignettes and tips on effective documentation and guidelines on charting are included.

In 1992, with the advent of the Medicare Physician Fee Schedule and the Resource Based Relative Value Scale, AMDA-The Society for Post- Acute and Long-Term Care Medicine (the Society) took the opportunity to help re-define the codes for nursing facility visits. At that time, six codes were approved. The rationale behind them was that they should reflect the work required by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) regulations and the Minimum Data Set (MDS).

In 1997, the Society participated in an American Medical Association (AMA)/Specialty Society Relative Values Scale Update Committee (RUC) survey of two additional Current Procedural Terminology (CPT™) codes for nursing facility discharge planning. The results of this survey were used to establish the work relative value units (RVUs) for services provided when discharging a patient from a nursing facility. These codes were implemented the following year.

In 2005, the Society submitted a proposal to the AMA's CPT™ Editorial Panel to redefine the original six nursing facility codes in order to keep pace with the changing model of the post-acute and long- term care continuum. Since the major revision of the codes in 1992, two developments had prompted a need for their revision. First, as hospital stays have become shorter, increased acuity of illness in nursing facility patients makes them more like the hospital population. Second, the CPT™ codes, which were tied to The Centers for Medicare & Medicaid Services (CMS) nursing facility regulations were not easily understood, unlike hospital visit codes which are familiar to most primary care physicians. To meet these developments, the codes were not only redefined but were given completely new numbers. New vignettes were provided and the

family of codes was expanded by the addition of two new codes. One new code re-established the annual assessment Minimum Data Set (MDS) update service (which had been displaced by the redefining of the Comprehensive Assessment codes). A second new code was added to the family of Subsequent Nursing Facility services to cover visits requiring comprehensive acute visits with high medical decision-making complexity.

In 2020, there was a large change in E/M codes. Following the implementation of the revisions to the Office/Outpatient E/M visits for the CPT™ 2021 code set, the AMA CPT/ RUC work group on E/M met to standardize the rest of the E/M sections in the CPT™ code set including the Nursing Facility Visits. CPT™ code 99318, the annual nursing facility assessment code was deleted, and the rest of the code set was revised to better align with the principles included in the E/M office visit services by documenting and selecting level of service based on total time or medical decision making (MDM). Effective January 1, 2023, the CPT codes reflect these updates with new descriptors indicating the level of care based on either the level of medical decision making or total time of the encounter.

THE CODES ARE AS FOLLOWS:	
Initial Nursing Facility Care (New or Established Patient)	**99304, 99305, 99306**
Subsequent Nursing Facility Care (New or Established Patient)	**99307, 99308, 99309, 99310**
Nursing Facility Discharge Services	**99315, 99316**
Prolonged Services	**G0317**

DOCUMENTING THE VISIT

The following information is provided as an introduction to clinical vignettes and documentation guidelines for each of the nursing facility codes.

HISTORY / EXAM

As of January 1, 2023, a medically appropriate history and/or exam remains a required element for all nursing facility services, but will not be a factor in the selection of the level of service. Note the importance of the history and exam in establishing medical necessity.

A comprehensive history includes reason for visit/chief complaint, history of present illness, medications, allergies, review of systems, and past, family, and/or social history all of which will help support and determine medical necessity. Although these are no longer factors in determining level of service they must be performed and documented as medically appropriate to ensure a proper evaluation of the patient. Initial visits and higher levels of subsequent codes will typically need more in-depth history to demonstrate medical necessity"

Examples of history/exam components:

Chief Complaint (CC): A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words. Alternatively, one can use The Reason for Visit, a concise reason for the visit. This is helpful for federally mandated visits or Initial Visits where a chief complaint is less pertinent

History of Present Illness (HPI): A chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI includes inquiring on the following elements: location, quality, severity, duration, timing, context, modifying factors, and

associated signs and symptoms, and helps support medical necessity.

Review of Systems (ROS): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. A ROS is still very useful for a comprehensive visit but can also be accomplished through the history of present illness documentation.

Past, Family, and/or Social History (PFSH): The PFSH consists of a review of three areas: Past history (the patient's past experiences with illnesses, operations, injuries and treatments); family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and social history (an age appropriate review of past and current activities).