KINDRED HEALTHCARE

Billing & Coding for SNF Physician Visits
SNF CPT Codes

• Initial Care Services
  – 99304
  – 99305
  – 99306

• Subsequent Care Services
  – 99307
  – 99308
  – 99309
  – 99310

• Discharge Services
  – 99315
  – 99316

• Annual
  – 99318

NOTE:
All visits must be “face to face”
Components and Levels of E/M Service

• History
  – **Problem focused** - Brief HPI; no ROS; no PFSH
  – **Expanded problem focused** – Brief HPI; ROS only pertinent to problem; no PFSH
  – **Detailed** – Extended HPI; extended ROS; PFSH only factors pertinent to problem
  – **Comprehensive** – Extended HPI; extended ROS; Complete PFSH

• Examination
  – **Problem focused** – limited exam of affected body area/organ system
  – **Expanded problem focused** – limited exam of affected AND related body area/organ system
  – **Detailed** – extended exam of affected AND related body area/organ system
  – **Comprehensive** – multi-system exam or thorough exam

• Medical Decision Making
  – **Straightforward** – minimal Dx or Tx; minimal data to review; minimal risk compl.
  – **Low** – limited Dx or Tx; limited data to review; low risk compl.
  – **Moderate** – multiple Dx or Tx; moderate data to review; moderate risk compl.
  – **High** – extensive Dx or Tx; extensive data to review; high risk compl.

HPI – History of Present Illness; ROS – Review of Systems; PFSH – Past Family & Social History; compli - complication
Frequency of Nursing Facility Visits

• As Required by Federal Regulation
  – “Following the Initial Visit by the physician, at least once every 30 days for the first 90 days and every 60 days thereafter” (note: the minimum)

• As Often As Medically Necessary
  – “For the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member - even if the visits are provided prior to the Initial Visit by the physician”

Source: Medicare Claims Processing Manual; 30.6.13 Nursing Facility Services
Initial Care Services

- 99304, 99305, 99306
- Used for:
  - Initial Admission or Readmission
  - Initial Consultation Visit (as of Jan 1, 2010)
- Three of three components required:
  - History
    - Detailed or Comprehensive
  - Examination
    - Detailed or Comprehensive
  - Medical Decision Making
    - Straightforward/Low or Moderate or High
Initial Care Services

• **99304** (three of three components required)
  - History – Detailed
  - Exam – Detailed
  - Medical Decision Making – Straightforward/Low

• VIGNETTE
  - Initial nursing facility admission visit for a 94 year old resident with vascular dementia and glaucoma who is no longer safe at home due to the development of wandering behavior. She takes eye drops for her glaucoma and no other medications. There were no changes in the medication plan and previous diagnostic work ups were complete.

*Source: AMDA Guide to Long Term Care Coding, Reimbursement and Documentation*
Initial Care Services

• **99305** (three of three components required)
  – History – Comprehensive
  – Exam – Comprehensive
  – Medical Decision Making – Moderate

• **VIGNETTE**
  – Initial skilled nursing facility admission visit for an 82 year old slightly confused white female who had an open reduction internal fixation on a hip fracture from a fall at her Assisted Living Facility. The patient has a history limited to chronic hypertension and osteoarthritis, well controlled on hydrochlorothiazide and acetaminophen. She has post surgical pain and has been provided a prescription for hydrocodone/acetaminophen and an order for physical and occupational therapy.

*Source: AMDA Guide to Long Term Care Coding, Reimbursement and Documentation*
Initial Care Services

- **99306** (three or three components required)
  - History – Comprehensive
  - Exam – Comprehensive
  - Medical Decision Making – High

- **VIGNETTE**
  - Initial skilled nursing facility admission visit for an 88 year old resident, who is being admitted for long term care after a hospitalization for urosepsis, respiratory failure, delirium and hyperglycemia, complicated by a worsening gait disorder, exacerbated by prolonged bed rest. His hospitalization was complicated by the development of *Clostridium difficile* colitis and a stage III sacral pressure ulcer. The resident was mildly forgetful prior to hospitalization, but developed delirium while septic, and remains profoundly confused, although improved over the last two weeks. He requires the completion of intravenous antibiotics for his urosepsis, the completion of oral antibiotics for his colitis, monitoring and adjustment of the insulin regimen, daily wound dressing changes as well as daily skilled rehabilitation services. He is on a total of 14 medications, including 2 antidepressants, and 2 psychotropic medications.

Source: AMDA Guide to Long Term Care Coding, Reimbursement and Documentation
Subsequent Care Services

• 99307, 99308, 99309, 99310
• Used for:
  – Medically necessary visits
  – Regulatory Required visits after the Initial Visit
  – Follow-up consultation visits
• Two of three components required
  – History
  – Examination
  – Medical Decision Making

Note: For Subsequent Care codes - Past History, Family History and Social History are NOT required
Subsequent Care Services

- **99307** (two of three components required)
  - History – Problem focused
  - Exam – Problem focused
  - Medical Decision Making – Straightforward

- Used for:
  - Patient Stable, recovering or improving
  - “Routine Regulatory” Visit

- **VIGNETTE**
  - Subsequent visit to evaluate an established patient who has been reported by nursing to have developed acute purulent conjunctival discharge. Physician exam confirmed bilateral inflamed conjunctivae and muco-purulent discharge in a patient in no distress who had no fever or scleral, corneal or periorbital involvement. An ophthalmic antibiotic is ordered.

Source: AMDA Guide to Long Term Care Coding, Reimbursement and Documentation
Subsequent Care Services

• **99308** (two of three components required)
  – History – Expanded Problem focused
  – Exam – Expanded Problem focused
  – Medical Decision Making – Low

• Used for:
  – Patient responding inadequately to treatment or developed minor complication
  – “Routine Regulatory” Visit

• **VIGNETTE**
  – Subsequent nursing facility visit to meet regulatory requirements to evaluate the following chronic medical conditions in a 93 year old at the nursing home for two years: Alzheimer’s dementia, hypertension and osteoarthritis on a cholinesterase inhibitor, a beta-blocker and acetaminophen PRN. No interval change in status and no new problems since the previous regulatory visit. Exam unchanged. No new medications prescribed. No new interventions needed.

Source: AMDA Guide to Long Term Care Coding, Reimbursement and Documentation
Subsequent Care Services

• **99309** (two of three components required)
  – History – Detailed
  – Exam – Detailed
  – Medical Decision Making – Moderate

• Used for:
  – Patient developed significant complication or significant new problem
  – “Routine Regulatory” Visit

• VIGNETTE
  – Subsequent visit to an established patient with a history of pulmonary fibrosis, atrial fibrillation, CHF, hypertension, hypothyroidism, cerebrovascular disease, an old CVA and TIAs who is reported by nursing to have increased dyspnea, new difficulty speaking and swallowing, increased pedal edema, increased anxiousness and confusion. There is no cough. Exam reveals Temp 97.5, BP 110/60, P 110, and RR 24. The cachectic, dyspneic patient is not cyanotic, has bilateral wheezing, fine bibasilar rales with no rubs or rhonchi, no increase in JVP but does have newly increased pedal edema and cardiac exam reveals a possible S3 gallop. Mild delirium on mental status exam. The remainder of the exam is at baseline. No lateralizing neurological signs including evaluation of the cranial nerves. The patient, although on O2 at 5L via mask, is running a pO2 saturation of 96%. CBC, BMP, BNP and CXR ordered but results not yet available. An initial dose of furosemide is administered pending results of the diagnostic work up.

Source: AMDA Guide to Long Term Care Coding, Reimbursement and Documentation
Subsequent Care Services

• **99310** (two of three components required)
  – History – Comprehensive
  – Exam – Comprehensive
  – Medical Decision Making – High

• Used for:
  – Patient may be unstable or may have developed a significant new problem requiring immediate physician attention

• VIGNETTE
  – Subsequent (emergent) nursing facility visit for the evaluation and management of a 75 year old chronic care resident with moderate dementia, diabetes mellitus, hypertension, obesity, chronic lymphedema, and recent but improving viral upper respiratory infection who presents with abrupt change of condition consisting of mental status changes with chest pain and moderate dyspnea. BP is lower than normal at 98/50, resp rate 28 and mildly labored, P 100, T 98 and O2 saturation on room air 86%. Physical exam reveals diminished breath sounds with a few rhonchi at both lung bases, distant heart sounds with frequent ectopy, benign abdomen, 3+ edema to knees right worse than left with mild erythema and tenderness worse than baseline. The family request that while the patient is not to be intubated or cardioverted in an emergency, they wish all possible diagnostic tests and treatment be performed at the facility. Relevant diagnostic tests are ordered while initial therapies are started, with close follow-up with nursing and family planned. A comprehensive review of all of the patient’s problems/co-morbidities was required.

Source: AMDA Guide to Long Term Care Coding, Reimbursement and Documentation
Discharge Services

- 99315 – 30 minutes or less
- 99316 – 30 minutes or more

- Total duration of time used for:
  - Final exam
  - Instructions for continuing care
  - Preparation of discharge records
  - Prescriptions
  - Referral forms
Annual Visit

• 99318 (three of three)
  – History – Detailed Interval
  – Examination – Comprehensive
  – Medical Decision Making – Low to Moderate

• Used for:
  – Annual exam
  – Usually the patient is stable recovering or improving
Visits by Qualified Nonphysician Practitioners

Federally Mandated Visits

- In SNF: Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets the collaboration and physician supervision requirement and is licensed as such by the State and performing within the scope of practice in that state. The NPP may also perform other medically necessary E/M visits
Consultant Services

- A consultation service is distinguished from other E/M visits because it is provided by a physician or qualified NPP whose opinion or advice regarding a specific problem is requested by another physician or other appropriate source.
- The reason for the consultation should be documented by the consultant in the patient’s medical record AND included in the requesting physician or NPP’s plan of care in the patient’s medical record.
Consultant Services

• CMS **ceased** paying for outpatient consultation codes (99241-99245) and inpatient consultation codes (99251-99255) as of January 1, 2010.

• Physician consultants should report *initial* SNF services (99304-99306) for the first patient encounter, and *subsequent* SNF services (99307-99310) for each encounter thereafter.

• The attending physician of record appends the assigned modifier (presumed to be “AI”) when submitting their initial care service. All other initial care codes are presumed to be those of “consulting” physicians.
## SNF vs. Hospital E/M Code Payments – 2012

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Rounded to nearest dollar. Does not account for geographic adjustment factor.