Billing Education Article By Dr. Rhonda Church

BILLING FOR SERVICES AT LONG-TERM CARE FACILITIES

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MSI has recently received a number of inquiries from physicians at long-term care facilities regarding how to correctly claim for residents of these facilities. This month, I'd like to share some of those questions with you.

Q: I'm a physician who looks after a long-term care facility and also cares for hospital inpatients. I make rounds at the nursing home the same day each week. Can I claim for a visit for each nursing home resident each week?

A: You may only claim for an institutional visit if there has been a specific request for you to address a medical concern of a nursing home resident by nursing home staff, the patient or the patient's family. While it's, of course, acceptable to consolidate these visits on one day for convenience purposes, a visit may only be claimed for patients for whom there has been such a specific request for you to attend the patient.

Q: I have a busy office practice and rather than interrupt my office by leaving to attend to a nursing home patient after a call from the nurse, I commonly see them on my way home or on the weekend. How do I claim for these after-hours visits?

A: Visits requested during one time period and performed during another must be claimed using the lesser of the two rates. This means if the nurse calls you at 2 p.m. and you visit the patient at 5:30 p.m., you must claim the visit using the daytime rate. If the call comes in after hours and you see the patient after hours, you may use the afterhour's rate. There must be a specific request and a medical necessity for seeing the patient after hours. If after-hours visits are audited, documentation of the time you were called and the time you visited are required on the patient record.

Q: When may I claim an urgent visit?

A: If the patient's condition is such that you must respond immediately, you may claim an urgent visit if your office has been interrupted and you must travel from your office to the nursing home. Travel is defined in the Preamble. Movement between nursing home rooms isn't considered travel, nor is movement between locations within a hospital.

Q: Speaking with family members of nursing home residents can be time-consuming and I'm wondering about claiming for this using a family therapy or other counselling code or the case management conference fee. Is this possible?

A: Talking with families can take up a great deal of time. Unfortunately, there's no way to claim for this under the existing Preamble rules and fee codes. These discussions don't qualify for family therapy and the case management conference fee may not be claimed in these circumstances. The case management conference fee is for an ad hoc multidisciplinary meeting to discuss the issues in the medical management of a patient at the request of nursing home staff. While there are times when family representation would be required at a multidisciplinary team meeting, this health service code can't be used when the family of a nursing home resident have requested a meeting to speak to the physician.

Q: I was very pleased to see the new fee for the Clinical Geriatric Assessment Many of the parts of the CGA form, such as the Mini Mental Status Exam and the Medication List, are completed by the nurses and/or are elsewhere in the chart. Is it acceptable to refer to other portions of the chart rather than completing these sections?

A: The intent of the Clinical Geriatric Assessment (CGA) is to provide an at-a-glance assessment of the patient's overall condition and level of frailty. It's intended to be portable such that it may travel with the patient, for example, to medical appointments outside the facility or to acute care facilities during times of serious illness. The physician must completely fill out the portions of the CGA designated as required by the physician, including the MMSE and medication list. It's not permissible to refer to other portions of the chart. The information must be available on the CGA.

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