Last year marked many interesting fiscal trends for the long-term care practitioner. In the December issue, I reviewed 2012 events and changes of interest to the LTC practitioner. This column will focus on billing and coding trends and the implications they have for the future of LTC service provision.

Changes in Visits and Charges
There was a general increase in Medicare Evaluation and Management or physician visit code (E/M) spending in all services of service for 4% in 2011, the last year completely analyzed (www.cms.gov, Research and Statistics, Medicare Part B Utilization). In the nursing home setting, there was a 6.5% 1-year increase and a 20% 2-year increase in nursing home E/M spending. All practitioner visits increased by 3.7% for 1 year and 9% for 2 years. The higher increases in spending compared with visits was due to, among other things, a slight increase in reimbursement, billing at higher E/M levels, and more initial visits by certain specialties.

Increase in E/M Frequency and Higher Level Codes
Both the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have expressed concern for the increased utilization of higher level codes and increased total visits at several sites of service, including nursing homes. Both have been shown to substantially contribute to the overall increasing costs of provider services. The OIG report “Coding Trends of Medicare Evaluation and Management Services” (OEL-04-10-00180, May 2012) noted that while the costs of all Part B services increased 43% in the past 10 years, the cost of E/M services increased 48%. CMS and OIG are both interested in several factors. What groups are making more visits? What codes are being used more? Are patterns changing in the nursing facility setting vs. the skilled nursing facility setting? Most importantly, do increased visits equal better value?

Upcoding
Upcoding refers to the tendency to bill at higher levels over time. This can occur for many reasons: more complex patients, better understanding of how to code for services provided, the use of electronic health records and more comprehensive documentation, and, at times, aggressive billing practices designed to maximize profit without necessarily providing the proper level of service.

CMS and OIG are, of course, concerned about the last issue. OIG analyzed data comparing the use of the top levels of E/M codes in each family of codes in the past decade and noticed a general increase in all sites of service. During the past 10 years, the use of the higher levels of code has gone from 22%-39% in the office setting, from 16%-23% in the hospital, and from 27%-48% in the ER.

Data for assisted living and nursing homes can be given for only the past 5 years due to significant changes in the CPT codes, but higher levels of codes have increased from 35%-45% for assisted living and from 31%-37% for nursing homes. OIG did note that its analysis showed that those physicians who consistently billed at higher levels of service treated beneficiaries of similar age and diagnoses than physicians using lower codes, suggesting improper billing by certain providers. OIG has recommended continued education of physicians on proper billing for E/M services, contractor review of physicians’ billing for E/M services, and review of physicians who bill higher level E/M codes for appropriate action. CMS has agreed with all but the last of these actions.

Where Visits Are Made
For many years, there was a general trend toward an increasing number of visits made in the skilled nursing facility as compared to the nursing facility. Recently, there has been a relative stabilization of the ratio of skilled nursing facility to nursing facility visits. Skilled nursing facility visits now average 59% and nursing facility visits average 41% of all visits since 2009. Relative increases in payment for skilled nursing facility services have been matched over the past several years by similar increases in nursing facility payments.

Changing Patterns in Nursing Home Visits
For years, the majority of nursing home visits were by the “traditional” group of physicians: internists (IMs – about 35% of all visits), family physicians (FPs – about 21%), geriatricians (GERs – 3%), and general practice (GPs – 3%). Nurse practitioners (NPs) usually made about 15% of all visits, with physician assistants (PA), psychiatrists (PSYS), and physical medicine and rehabilitation (PMRs), each making about 2% of all visits. The complaints were made by podiatrists and a variety of specialists.

There has been a substantial change over the past 3 years, however. NPs now make 24% of all visits – more than FPs, who have dropped to 19% of all visits. IMs and GERs have both increased their percentage of all visits by a couple of points. While the total number of visits made by PMRs and PSYS remain somewhat small, they have increased the number of visits they make by 22% and 10%, respectively. Since PMRs and PSYS have a higher initial-to-subsequent visit ratio than most other providers in the nursing home setting, their actual charges increased by 36% and 22%, respectively – more than any other provider type.

The net effect of these changes is that the traditional providers (IMs, FPs, GERs, and GPs) have gone from making 62% off all visits in 2009 to 56% in 2011. Conversely, the “nontraditional” providers (NPs, PAs, and PMRs) have gone from making 21% of all visits in 2009 to 28% in 2011. In terms of absolute number of visits, the traditional providers have had a 0.3% decrease in number of visits from 2009 to 2011, while the nontraditional providers have increased the number of visits in this same time period by 46%. The majority of increased E/M-service spending over the past 2 years in the nursing home setting, as would be expected, is mainly due to the increase in nontraditional providers.

Billing Patterns
Different providers have shown different changes in E/M code billing patterns from 2009 to 2011. Percentage increases in initial-code visits were most noteworthy for PMRs (250%), PSYS (238%), and NP/PAs (both 122%). Percentage increases in subsequent codes were not as remarkable during this period. Minimal increases were seen by most providers except NPs (27%), PAs (30%), and GERs (13%).

High-level nursing home E/M code usage also varied by specialty in 2011. The highest level initial-visit code (99306), compared with the family of initial visits, was used 74% of the time by GERs, 63% of the time by IMs, and 53% of the time by FPs. Similar numbers for PMRs are 53%, for PSYS 51%, for NPs 47%, and for PAs 41% (while NPs and PAs cannot make initial visits in the SNF, they can, at a state’s discretion, make nursing facility visits, so a lower level of complexity would be expected).

The highest level of subsequent-visit codes (99309 and 99310), compared with the family of subsequent codes, was used 42% of the time by GERs, 40% of the time by IMs, and 30% of the time by FPs. Similar numbers for NPs are 42%, for PSYS 40%, for PAs 37%, and for PMRs 20%. Overall, GER and IM used the highest levels of codes the most often. This may be theoretically due to their seeing the most complex patients, although there is not good data currently to support this.

Future Implications
Everyone practicing in the nursing home setting wants to improve the quality of care of residents. The million dollar question is: Does the increase in practitioner visits and reimbursement equal improved quality? There is evidence that the increased presence of NPs in the nursing home can affect quality, and there is evidence that a qualified medical director can affect quality. The CPT codes for nursing home care were changed and re-evaluated for increased reimbursement due in good part to the increased complexity of nursing home residents, making a potential argument for higher levels and more frequent visits. There are many resident needs – such as transitions of care, rapid identification of change in condition, and medication management – that could justify more frequent and higher levels of E/M nursing home visits. Overall, there is insufficient evidence to date that the 2-year increases seen in nursing home visits for all provider types are directly correlated with improved quality of care.

There is general concern that the current fee-for-service system does not support coordinated care that provides for optimal quality across the entire health care system. Many new systems of care, such as accountable care organizations, are just beginning to enter the LTC arena. Such systems will probably continue the trend to a multiple-discipline presence in the nursing home and will provide the opportunity for all practitioners to work more closely with the nursing home, resident, and each other to improve quality of care.

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