Updates in Coding & Billing Strategies.

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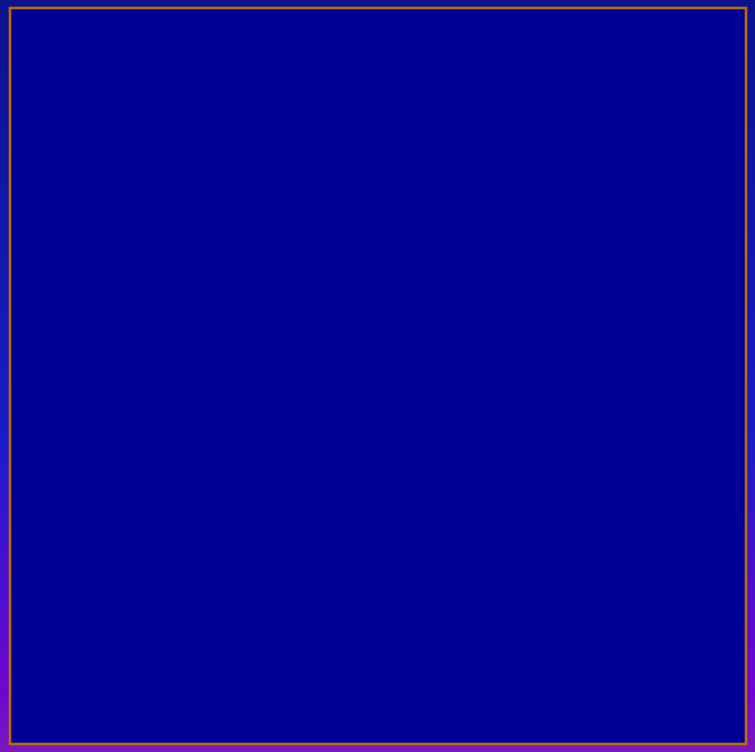
Updates in Coding & Billing Strategies



Drew Keister, MD, FAAFP

Disclaimer

- I am not an expert coder
- My goals:
  - Provide basic information
  - Start dialogue
- Please correct me if I have made mistakes

Agenda

- Issue of resident undercoding
  - Primary Care Exception
  - Level 4 visits
- Transitions of Care
- Chronic Care Management
- Advanced Care billing

Undercoding in residency

- Recently at one CCS in my residency:
  - Faculty 2:1 of 99214 vs. 99213
  - Residents 1:2
- Why?

Why care?

- One study estimated that physicians who were undercoding potential 99214s had annual loss of **$57,600** per physician

How to get all the 99214s you deserve. Fam Pract Manag. 2003 Oct;10(9):31-6.

And oh by the way…

https://wattsupwiththat.com/2016/09/03/two-hundred-million-dollar-scientific-grant-fraud-case/

Just a reminder

- Primary Care Exception

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf

  or Google: “Primary Care Exception”

Primary Care Exception

- E&M Codes covered
  - New and Established levels 1-3
  - i.e. 99201, 99202, 99203; 99211, 99212, 99213
- HCPCS- Medicare preventative visits
  - Welcome to Medicare (G0402)
  - Initial annual (G0438)
  - Subsequent annual (G0439)

Primary Care Exception

- Must be continuity FMP that is used to calculate time for DGME payments
- Residents must be 6+ mos into residency
- Don’t supervise > 4 residents
- Review care “during or immediately after” visit

Recommendation: Education

- Teach residents 99214 mindset

- Think of required elements WHILE taking hx
- Don’t move onto PE until have required hx
- Document A/P: using right verbiage
  - Get credit for the work you do!!

Coding a 99214 based on time

- Spend 25+ minutes with patient, **AND**
- Spend > 50% on counseling or coordination of care
- Should document a few sentences describing your efforts, total time spent, and that >50% was on counseling/coordination of care

- **Can residents do this?**

Other recommendations?

- Preceptor availability
- POwER precepting
  - Prepare, Orchestrate, (work), Educate, Review
  - http://www.stfm.org/fmhub/fm2005/march/david205.pdf

Transitions of Care

- Meant to facilitate good transition from hospital to office
- FM uniquely poised to do this work
- Excellent reimbursement!!!
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf OR GOOGLE: Transition of Care Billing

Transitional Care Management (TCM) Services Criteria

- Services required during transition to the community setting following particular kinds of discharges:
  - Inpatient Acute Care Hospital
  - Inpatient Psychiatric Hospital
  - Long Term Care Hospital
  - Skilled Nursing Facility
  - Inpatient Rehabilitation Facility
  - Hospital outpatient observation or partial hospitalization
  - Partial hospitalization at a Community Mental Health Center

Transitional Care Management (TCM) Services Criteria

- Discharge must be to a community setting:
  - Home
  - His or her domiciliary
  - A rest home
  - Assisted living
- No gaps in care- The health care professional accepts care of the beneficiary post-discharge
- The health care professional takes responsibility for the beneficiary's care

Transitional Care Management (TCM) Services Criteria

- Pt has medical and/or psychosocial problems that require moderate or high complexity medical decision making

- The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days

TCM Requirements- Interactive contact

- Within 2 days
- Email, phone or face-to-face
- If you can’t reach them…
  - Keep trying!!
  - If you get them in time for face-to-face and you document your attempts OK to bill TCM code

TCM Services- Non face-to-face (By clinician)

- Obtain and review discharge information
- Review need for or follow-up on pending diagnostic tests and treatments
- Interact with other professionals who will assume/ reassume care of system-specific problems
- Provide education to the beneficiary, family, guardian, and/or caregiver
- Establish or re-establish referrals and arrange for needed community resources
- Assist in scheduling required follow-up with community providers and services

TCM Services- non-face-to-face (Someone else)

- Communicate with agencies and community services the beneficiary uses
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living
- Assess and support treatment regimen adherence and medication management
- Identify available community &health resources
- Assist the beneficiary and/or family in accessing needed care and services

TCM Services- face-to-face

- CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge) – **2.11 wRVU**
- CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge) – ***3.05 wRVU***
- The face-to-face visit is part of the TCM service, and you should not report it separately

Levels of Decision Making

Elements for Each Level of Medical Decision Making

Type of Decision Making	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

Minimum Documentation

- Date the beneficiary was discharged.
- Date you made an interactive contact with the beneficiary and/or caregiver.
- Date you furnished the face-to-face visit.
- The complexity of medical decision making (moderate or high).

TCM via telehealth

- Effective for services furnished on or after January 1, 2014, you may furnish CPT codes 99495 and 99496 through telehealth.

- This would replace face-to-face

TCM Services- The Rub

- Only one health care professional may report TCM services.
- The same doc may discharge and bill TCM
  - BUT required face-to-face visit may not take place on the same day as discharge
- Can’t bill in 30-day post-op global period

Thoughts/Questions?

Chronic Care Management

- Began Jan 1, 2015
- Non face-to-face coordination of care… to pts with multiple chronic conditions

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf OR GOOGLE: “Chronic Care Management Billing”

Chronic Care Management

- At least 20 minutes of clinical staff time per mo
- Directed by a physician or APC

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- Chronic conditions place patient at significant risk of death, acute exacerbation/ decompensation, or functional decline,
- Comprehensive care plan established, implemented, revised, or monitored.

- Code: 99490 - wRVU: 0.61
- Cannot add up time over multiple months
- Do not need to bill every month

Must begin with…

- CMS requires the billing practitioner to furnish a comprehensive evaluation and management (E/M) visit, Annual Wellness Visit, or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service, and to initiate the CCM service as part Patient Agreement of this visit/exam
- Need pt consent

Consent requirements

- Inform patient of the availability and obtain written agreement to have the services provided
  - Includes authorization for the electronic communication of medical information with other treating practitioners
- Explain and offer the CCM service to the patient.
- Document this discussion in EMR and note the patient's decision to accept or decline the service.
- Explain how to revoke the service.
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.

4 Requirements

1. Structured Data Recording
2. Care plan documents
3. Access to Care
4. Manage Care

Requirements

- Structured Data Recording – in eligible EHR
- Care plan documents
  - Biopsychosocial approach
  - Copy to pt and document this in EHR
  - Plan always available within practice
  - Share outside practice prn

Care plan components

- Problem list w/ Expected outcome & prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management;
- Community/social services ordered;
- A description of how services of agencies and specialists outside the practice will be directed/coordinated;
- Schedule for periodic review and, when applicable, revision of the care plan.

Access to Care

- Ensure 24/7 access to care management services
- Ensure continuity of care with a designated member of the care team
- Provide enhanced opportunities for the patient and any caregiver to communicate
  - Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Manage Care (including…)

- Systematic assessment of the patient's medical, functional, and psychosocial needs
- System-based approaches to ensure timely receipt of all preventive care services;
- Med rec w/ review of adherence & interactions
- Oversight of patient self-mgmt of medications. `
- Manage care transitions between and among health care providers and settings, including: follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities. `
- Coordinate care with home and community based clinical service providers

Advanced Care Planning Services

- Codes to cover discussion and documentation of advanced directives and end of life decision-making
- Simpler than the others to document
- Still lucrative

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Advanced Care Planning Services

- 99497 – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate.
  - wRVUs: 2.4
- 99498 – SAME- each additional 30 minutes.
  - wRVUs: 2.09

No limits?

- No limit to how often
- No limit to facility type (includes hospital and hursing home)
- No advanced directive needs to be completed
- No specific diagnosis
- Consent is needed (so some limits…)

Documentation

- Examples of appropriate documentation would include:
  - an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter;
  - documentation indicating the explanation of advance directives (along with completion of those forms, when performed);
  - who was present; and
  - the time spent in the face-to-face encounter.

Jedi Coding Master

https://encrypted-tbn2.gstatic.com/images?q=tbn:ANd9GcQRjRxy0CDd6FnK5TVV8olMIysxF1-ViXJX3cmE4PlZo0WZDpse